Electronically Delivered

March 5, 2025

Licensee
Fieldcrest Assisted Living
80 Vermillion Street East
Cottonwood, MN 56229

RE: Project Number(s) SL36858016

Dear Licensee:

On January 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 14, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Electronically Delivered

December 19, 2024

Licensee
Fieldcrest Assisted Living
80 Vermillion Street East
Cottonwood, MN 56229

RE: Project Number(s) SL36858016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2024, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36858016-0 On November 12, 2024, through November 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility license. 1750: An immediate correction order was identified on November 13, 2024, at a level 3/Widespread (I). The liecnsee developed a plan to correct the citation, but the scope and level remains at I. 1950: An immediate correction order was identified on November 13, 2024, at a level 3/Widespread (I). The liecnsee developed a plan to correct the citation, but the scope and level remains at I.	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.	

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0 115	Continued From page 1	0 115		
0 115 SS=D	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an assisted living with dementia care license was in place while using a WanderGuard device for one of sixteen residents. 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 was licensed as an assisted living facility.	0 115		

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0 115	Continued From page 2 On November 12, 2024, at 9:05 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated two doors at the end of the hallways had alarms. Residents were able to exit the doors and alarms would sound, but they were not able to enter through those doors. At 9:32 a.m., ALDIR/CNS-A further stated the doors were equipped with a Wanderguard system; therefore, if a resident was having problems with wandering they could utilize a Wanderguard bracelet. On November 12, 2024, at 12:48 p.m., ALDIR/CNS-A stated R1 had an elopement incident and they were using a Wanderguard bracelet on her. The Wanderguard system in use was alarm only and the doors did not lock, but if R1 attempted to leave the facility, alarms would sound. ALDIR/CNS-A stated they have tried to find alternative placement in a memory care unit and have tried to talk to R1's family and social worker to get assistance with it, but have not had responses from them. They have also increased safety checks on R1. R1's Incident Report dated October 6, 2024, indicated at 4:53 p.m. an unlicensed personnel (ULP) was notified by a member of the community that R1 was walking down the street. The ULP immediately notified ALDIR/CNS-A and was going to pick R1 up when the community member returned R1 to the facility. A Wanderguard bracelet was placed on R1 for safety. According to the incident report, additional interventions included looking for alternative placement in a memory care unit and additional safety checks were implemented. R1's Clinical Update Assessment dated October	0 115		

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0 115	Continued From page 3 9, 2024, identified: - "[R1] is unable to leave the facility without a companion. Nurse has contacted family multiple times and they have never returned the call back. Nurse has contacted social worker many times for concern of [R1]'s elopement. Nurse has reached out to local memory care units and has [R1] on waiting lists. Nurse has also reached out to social worker to assist with further placement with no response. [R1] also has a wander guard placed on her wrist that will alert staff when [R1] leaves the building. Staff will follow scheduled services and safety checks." - [R1] on 7/3/23 went to an appointment and walked out of the appointment and did not get on the MAT bus. Facility called police and [R1] was brought back to the facility. [R1] has tried many times to leave the facility to go on a walk without permission. [R1]'s walk out of the facility on 10/6/24 and got lost on her walk. A local brought [R1] back to [facility]." R1's Service Recap Summary for November 2024, identify R1 receives services that require staff to be in R1's presence and/or safety checks at 2:00 a.m., 5:00 a.m., 8:00 a.m., 9:00 a.m., 11:45 a.m., 12:00 p.m., 1:00 p.m., 2:00 p.m., 3:00 p.m., 4:00 p.m., 4:45 p.m., 5:00 p.m., 8:00 p.m., and 9:00 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 115		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 4 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was evaluated twice a year as required. This practice resulted in a level two violation (a violation that did not harm a licensee'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	0 470		

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0 470	Continued From page 5 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license, was licensed for a capacity of 25 residents, and had a current census of 16 residents. The licensee's Master Staffing Plan was undated and identified the facility determined staffing needs based on the needs of the residents. The staffing plan had not been reviewed twice a year as required. On November 14, 2024, at 9:30 a.m. registered nurse (RN)-B stated she was unaware the staffing plan had to be reviewed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food 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	0 480		

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0 480	Continued From page 6 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean 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.	0 480		

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0 480	Continued From page 7 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 November 13, 2024, 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=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	0 510		

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0 510	Continued From page 8 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 infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for two of two employees (unlicensed personnel (ULP)-G, ULP-D). 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: ULP-G On November 13, 2024, during continuous observation, unlicensed personnel (ULP)-G was observed completing the following tasks: - 6:26 a.m. ULP-G administered oral medications to R3. - 6:30 a.m. ULP-G entered R5's room, ULP-G asked if she could put on her right knee brace and R5 agreed. ULP-G placed the elastic brace on R5's knee fastening with the Velcro straps. ULP-G then removed garbage from the room.	0 510		

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0 510	Continued From page 9 - 6:35 a.m. ULP-G took garbage out to the dumpster outside and returned inside to the office. unlocked the door and went in and began documenting on the tablet. - 6:45 a.m. ULP-G entered R6's room gave her a glass of water touching the drinking rim of the cup and encouraged her to drink fluids, straightened the blanket on her lap, and exited the room. ULP-G did not wash hands or use hand sanitizer throughout the entire observation. ULP-D On November 13, 2024, at 7:15 a.m., ULP-D entered R6's room, unlocked the medication cabinet, prepared medications for administration and administered oral medications to R6. ULP-D exited R6's room. ULP-D did not use hand sanitizer or wash hands. ULP-D entered R3's room, prepared medications for administration and administered R3's medications. After ULP-D was finished, they used hand sanitizer upon exiting R3's room. On November 13, 2024, at 8:13 a.m., ULP-D stated they used hand sanitizer in between rooms, and every four to five rooms ULP-D will wash their hands. On November 13, 2024, at 9:45 a.m. assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated staff should use hand sanitizer between residents and should wash there hands anytime they are contaminated. If staff are assisting with toileting or come into contact with body fluids. If staff are wearing gloves and remove them, or if they are doing blood glucose monitoring then staff should wash hands after. They should sanitize or wash hands between each resident during a medication pass.	0 510		

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0 510	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 640		

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	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
0 640	Continued From page 11 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, at 9:50 a.m. during a facility tour with assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A, a facility telephone was noted near the dining area and activity room. There was no signage for calling 911 in an emergency noted on or near the phone. ALDIR/CNS-A stated she was unaware 911 needed to be posted by the facility phones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	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.	0 660		

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0 660	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees ((ULP)-G and ULP-I). This had the potential to affect all residents and staff of the facility. 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: ULP-G ULP-G was hired on October 7, 2024, and provided direct care services to the residents. ULP-G's employee record included a TB symptom screen dated October 7, 2024, and documentation indicating a TST was administered on October 7, 2024, and read on October 9, 2024, with negative results. ULP-G's record lacked evidence a second TST had been completed. ULP-I ULP-I was hired on October 16, 2024, and provided direct care services to the residents.	0 660		

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0 660	Continued From page 13 ULP-I's employee record included a TB symptom screen dated October 16, 2024, and documentation indicating a TST was administered on October 16, 2024, and read on October 18, 2024, with negative results. ULP-I's record lacked evidence a second TST had been completed. On November 14, 2024, at 9:06 a.m., clinical director/registered nurse (CD/RN)-B stated ULP-G had not responded and come in for her second step TST because CD/RN-B had sent the text to a wrong number. CD/RN-B further stated at 10:22 a.m. ULP-I was another employee who did not respond when sent a text to come in for her second TST. The licensee's Tuberculosis Risk Assessment Policy & Procedure policy dated February 2022, indicated staff were required to have a two step TST or the TB blood test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The	0 660		

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0 660	Continued From page 14 second TST may be performed after the HCW starts working with patients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 15 Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents. 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: The licensee's Emergency Preparedness Plan dated January 2024, included a Hazard and Vulnerability Assessment Tool and policies and procedures related to natural and man-made disasters; however, the licensee's plan lacked the following required content: - identification of the at risk population needs; - quarterly review of the missing resident plan; and - two full scale drills or one full scale drill and one table top exercise completed in the last year. The licensee's Missing Client and Patient Elopement Policy was dated April 2023. On November 12, 2024, at 2:04 p.m., quality coordinator (QC)-F stated she was unable to locate the identification of the at risk population needs in the emergency preparedness plan and the facility had only completed the required fire drills and a tornado drill in the spring. On November 14, 2024, at 12:05 p.m., clinical	0 680		

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0 680	Continued From page 16 director/registered nurse (CD/RN)-B stated she was unaware the missing resident policy needed to reviewed quarterly. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 17 by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on November 12, 2024, from 10:43 a.m. through 11:30 a.m., with assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A, the surveyor observed the following: The fire-resistant rated doors leading into the laundry room and mechanical room had automatic door closer that did not fully close and latch the doors. Fire-resistant rated doors are required to automatically close and latch to prevent the spread of smoke and fire into adjoining building areas. ALDIR/CNS-A stated they would have maintenance personnel adjust the doors. The East wing sunroom hallway was part of a marked emergency exit path and was partially blocked by two beds. ALDIR/CNS-A stated that one bed was stored in that area and the other one was used by staff overnight or during bad weather.	0 780		

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0 780	Continued From page 18 The West wing sunroom hallway was part of a marked emergency exit path that was partially blocked with a treadmill and a chair. Emergency exits must be maintained free of obstructions, so they are available to use during a fire or similar emergency. ALDIR/CNS-A verified the above conditions during the tour and stated they would remove the items from the sunroom hallways. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 810		

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0 810	Continued From page 19 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, at 11:40 a.m., quality coordinator (QC)-F provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 20 The licensee's FSEP, titled "Fire Response Policy", revised September 2023, failed to provide the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on November 12, 2024, at 12:05 p.m., QC-F and assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on November 12, 2024, at 12:05 p.m., QC-F stated they provide training to employees at hire and annually. QC-F stated they have not been offering training to residents, but they talk to residents during evacuation drills. The surveyor explained the requirements for training	0 810		

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0 810	Continued From page 21 employees upon hire and twice annually and annually offering training to residents. QC-F and ALDIR/CNS-A stated they understood the requirement for training staff and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated	0 950		

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0 950	Continued From page 22 representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required verbatim language giving residents the right to identify a designated representative on it's own separate page for two of two residents (R1 and R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the assisted living licensee on June 1, 2023. R1's Resident Agreement signed June 1, 2024, page one included "Designated Representative (name/contact)". Hand written on the top line was "does not have one, self". The Agreement included "If Resident declines to name a Designated Representative, Resident please initial here" with a box the resident could initial. R1's record lacked evidence they had been provided the following verbatim notice on a document separate from the contract as required: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 23 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted to the assisted living licensee on August 6, 2024. R2's Resident Agreement signed June 1, 2024, page one included "Designated Representative (name/contact)" with lines which were filled in with R2's designated representatives information. The Agreement also included "If Resident declines to name a Designated Representative, Resident please initial here" with a box the resident could initial. R2's record lacked evidence they had been provided the following verbatim notice on a document separate from the contract as required: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of	0 950		

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0 950	Continued From page 24 attorney ("health care agent"), if applicable." On November 14, 2024, at 1:50 p.m. clinical director/registered nurse (CD/RN)-B stated she was unaware of the required verbatim notice required on a separate document from the contract and all contracts would be the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

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01060	Continued From page 25 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R11). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required. 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).	01060		

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01060	Continued From page 26 The findings include: R11's incident report dated June 16, 2024, indicated R11 was yelling for help and complaining "she could not breathe". R11 indicated she had pain in the chest, back, stomach, neck, head and left arm. R11 was transported by ambulance to the emergency room. R11's Discharge Care Plan dated June 21, 2024, included the following "[R11] was sent to the ER on 6/16/24 she was then admitted to the hospital. At the hospital they put her on comfort cares and was looking to be discharged back to [facility] on Hospice. Nurse went to assess [R1] on 6/20/24 and noticed [R1] exceeds care at the facility and is unable to transfer back to [R1]. [R1] was transferred from the hospital to [nursing home] on 6/21/24." R11's record lacked evidence the resident and/or the resident's representative had been provided, as soon as practicable, a written notice that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 27 may submit an appeal. R11's record also failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days. On November 14, 2024, at 1:54 p.m., clinical director/registered nurse (CD/RN)-B stated she was unaware of the emergency transfer notifications. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a	01290		

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01290	Continued From page 28 background study was submitted and received in affiliation with the assisted living license for four of four employees (unlicensed personnel (ULP)-D, ULP-G, ULP-H, and ULP-I). This had the potential to affect all residents living in the assisted living facility. 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: ULP-D ULP-D was hired on August 17, 2021, to provide direct care services to the facility's residents. On November 12, 2024, at 11:27 a.m., the surveyor observed ULP-D administer medications to R5. On November 13, 2024, at 7:15 a.m., the surveyor observed ULP-D administer medications to R6, R3, and R7. ULP-D had a background study completed August 17, 2021, affiliated with health facility identification number (HFID) 2384, which was another licensee owned by the same company. ULP-D's background study was not affiliated with the assisted living facility (ALF) license. ULP-G ULP-G was hired on October 7, 2024, to provide direct care services to the facility's residents.	01290		

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01290	Continued From page 29 On November 13, 2024, at 6:26 a.m., the surveyor observed ULP-G administer medications to R3. NETStudy roster printed on November 12, 2024, at 1:25 p.m. identified ULP-G had been affiliated to the licensee's HFID on November 12, 2024 (the day survey was initiated). ULP-H ULP-H was hired on October 9, 2023, to provide direct care services to the facility's residents. On November 13, 2024, the surveyor observed ULP-H administer medications to R2, R8, and R1. NETStudy roster printed on November 12, 2024, at 1:25 p.m. identified ULP-H had been affiliated to the licensee's HFID on November 12, 2024 (the day survey was initiated). ULP-I ULP-I was hired on October 16, 2024, and provided direct care services to the residents. NETStudy roster printed on November 12, 2024, at 1:25 p.m., identified ULP-I had been affiliated to the licensee's HFID on November 12, 2024 (the day survey was initiated). On November 12, 2024, at 3:32 p.m. assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the background studies had been run through the home care company HFID 2384 and she was unaware they needed to be affiliated to the ALF HFID until the surveyor had requested them.	01290		

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01290	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 31 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one contracted employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services. 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	01470		

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01470	Continued From page 32 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was contracted through an outside nurse staffing agency and began providing assisted living services for the licensee on January 18, 2024. On November 12, 2024, beginning at 11:13 a.m., the surveyor observed ULP-E completing the following: - administered oral medications to R3 - checked R4's phone and noted blood glucose results to be 107, and administered R4's oral medications - checked R10's blood glucose ULP-E's record contained a form titled, "[Agency name] Employee Check List" which included emergency training information and location of facility policies and procedures. ULP-E's record lacked evidence of orientation in the following required topics: (1) an overview of assisted living statutes; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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01470	Continued From page 33 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 12, 2024, at 12:56 p.m., ULP-E stated on her first day at the facility, the facility's unlicensed staff showed her around the facility, instructed her on what the residents' needs were, and how to use the electronic documentation system. The ULP staff showed her where the information for agency staff was kept in a folder and went through the checklist with ULP-E. On November 13, 2024, at 12:46 a.m., assisted living director in residence/clinical nurse supervisor (ALDIR/CNS)-A stated when agency staff come to the facility, they review the [Agency name] Employee Check List form with another ULP. There is no place for the facility's staff to sign. ALDIR/CNS-A stated she was unaware the agency staff needed to have orientation and it was not portable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 34 (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 observation, interview, and record review, the licensee failed to ensure one of two residents (R2) had a service plan signed by the resident within 14 days. 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).	01640		

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01640	Continued From page 35 The findings include: On November 13, 2024, at 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications to R2. R2 was admitted and began receiving services on August 6, 2024. R2's contract was signed on August 6, 2024. R2's admission assessment was dated August 6, 2024, indicating R6 admitted on August 6, 2024, and received assistance with meals, blood glucose monitoring, insulin administration, medication administration, medication management and medication set up. R2's Service Plan was printed on August 27, 2024, and was signed on September 10, 2024. R2's service plan indicated services included bathing assistance, medication management and administration, blood glucose monitoring, dressing reminders and meals. An email received on November 14, 2024, at 2:24 p.m., from clinical director/registered nurse (CD/RN)-B indicated R2's service plan was printed on August 27, 2024, but it was not signed until September 10, 2024. The licensee's Service Plan Revision Policy dated March 2020, indicated "No later than 14 days after the initiation of non-delegated assisted living services but prior to the initiation of any delegated assisted living services, the RN, and the therapist or other licensed health professional, develops and finalizes an individualized service plan for the resident."	01640		

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01640	Continued From page 36 No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel (ULP-E, ULP-G, and ULP-H) completed training and/or competency evaluations for medication administration with a registered nurse (RN) prior to administering medications. This resulted in an immediate correction order identified on November 13, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01750		

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01750	Continued From page 37 has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was contracted through an outside nurse staffing agency and began providing assisted living services for the licensee on January 18, 2024. On November 12, 2024, beginning at 11:13 a.m., ULP-E was observed completing the following: - administered oral medications to R3 - checked R4's phone and noted blood glucose results to be 107. ULP-E stated R4 does not get any insulin. ULP-E then administered oral medications and encouraged R4 to eat something for lunch since her blood glucose was 107. - Checked R10's blood glucose results to be 140. ULP-E stated R10 does not get any insulin since it is below 150. ULP-E's record contained a form titled, "[Agency name] Employee Check List" included facility information, how to use facility equipment, and fire information, and the bottom of the form included a section titled, "Sheets to Read and Go Over" with an "X" in front of each of the following: - Blood Glucose Competency - Planned or Unplanned Time Away Medication Set Up - Insulin Administration - Medication Administration The document was signed and dated by ULP-E on January 18, 2024. Included with this document was a blank Blood Glucose Competency form, a blank Insulin Administration form, a blank Medication	01750		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
01750	Continued From page 38 Administration form which included all routes of medication administration, and a blank Planned or Unplanned Time Away Medication Set Up form. ULP-E's file lacked evidence ULP-E had been trained or competency tested by the facility's RN prior to administering medications. R10's MAR dated November 2024, identified insulin aspart (Novolog) FlexPen ordered three times a day to be administered per sliding scale SLIDING SCALE: 0 units: 0-150 3 units: 151-199 6 units: 200-249 9 units: 250-299 12 units: 300-349 15 units: >350 R10's MAR further identified on November 12, 2024, at 8:00 a.m. R4's blood glucose was 174 and ULP-E administered 3 units of insulin. On November 12, 2024, at 12:56 p.m., ULP-E stated on her first day at the facility, the facility's unlicensed staff showed her around the facility, instructed her on what the residents' needs were, and how to use the electronic documentation system. The ULP staff showed her where the information for agency staff was kept in a folder and went through the checklist with ULP-E. ULP-E stated since she was a certified nursing assistant (CNA) and a trained medication aide (TMA) she knew what to do. The facility RN did not train or competency test her prior to her providing medication administration to the residents. On November 13, 2024, at 12:46 a.m., assisted	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
01750	Continued From page 39 living director in residence/clinical nurse specialist (ALDIR/CNS)-A stated when agency staff come to the facility, they review the [Agency name] Employee Check List form with another ULP. There is no place for the facility's staff to sign. ALDIR/CNS-A stated she does not do any medication training or competency testing with the agency staff because they should have that through the agency. ALDIR/CNS-A stated she was unaware medication competencies were not transferable. ULP-G On November 13, 2024, at 6:26 a.m., ULP-G was observed administering medications to R3. ULP-G was hired on October 7, 2024, to provide direct care services to the facility's residents. ULP-G's employee record indicated she was competency tested by the facility's RN for medication administration on October 15, 2024. R5's Medication Administration Record (MAR) dated October 2024, identified on October 12, 2024, ULP-G administered medications to R5 at 5:56 a.m. On November 13, 2024, at 6:35 a.m., ULP-G stated she had been hired in October 2024. She completed online training and then began training on the floor with another ULP. The first night she observed the ULP; the second night she observed but she began doing some tasks such as housekeeping, baths, and oral medications; and on the third night she did everything with the other ULP observing her including all treatments and medications such as insulins and blood glucose monitoring; however, she was never unsupervised. A couple of days later, the RN met	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
01750	Continued From page 40 with her for about half an hour and verbally went though everything with her and signed her off, but the RN did not observe her administering the medications or completing treatments. ULP-G stated she has been in the field for a long time in another state and has been a CNA and TMA; therefore, she knows how to do the job. ULP-H On November 13, 2024, ULP-H was observed completing the following: - at 8:14 a.m., set up R2's glargine insulin pen for administration. During administration, the safety needle was observed by the surveyor to be pressed lightly to the skin and upon removal, a large drop of clear liquid rolled down R2's abdomen. ULP-H stated that usually happens, and ULP-H wiped it away with the alcohol wipe. ULP-H then administered oral medications to R2. - at 8:29 a.m., ULP-H administered medications to R8 - at 8:38 a.m., ULP-H administered medications to R1 ULP-H was hired on October 9, 2023, to provide direct care services to the facility's residents. ULP-H's employee record indicated she was competency tested by the facility's RN for medication administration on October 24, 2023. On November 13, 2024, at 8:42 a.m., ULP-H stated when she was trained, ULP-H initially completed the online training and then she trained with another ULP. On the first day, ULP-H observed the other staff; on the second day, ULP-H stated she did more hands on cares such as compression stockings, dressing, and oral medications; on the third day and subsequent days, ULP-H administered all routes of	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
01750	Continued From page 41 medications to include insulin, and also completed blood glucose monitoring and other treatments. ULP-H was supervised by the other unlicensed staff. ULP-H stated the RN completed the training and competency testing after the online training and the training had been completed with the other ULP. On November 13, 2024, at 9:45 a.m., ALDIR/CNS-A stated staff initially complete the online training modules and then they train onsite with another ULP. Typically there are three training shifts where ALDIR/CNS-A checks to see how the ULP are doing and to see if they need more training or if they are doing well enough. ALDIR/CHS-A competency tested them at that time and then they are working independently. ULP observe for the first shift, start passing oral medications and helping with cares on the second shift, and then completing all medication routes and treatments by the third shift. Therefore, staff are completing those tasks prior to being competency tested by the RN. ALDIR/CNS-A stated she was unaware competency testing had to be completed prior to ULP administering the medications. In regards to the insulin administration on November 13, 2024, at 8:14 a.m., ALDIR/CNS-A stated it would be unusual for that much liquid to leak out after an insulin injection and she is unsure why that would occur if it was properly administered. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks Policy dated March 2020, indicated Steps Prior to Delegating Medication Administration. A Registered Nurse may delegate medication administration to unlicensed personnel only after the RN has: a. Instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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	36858	A. BUILDING: _____ B. WING _____	11/14/2024

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FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

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01750	Continued From page 42 and the unlicensed personnel has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 14, 2024, the licensee developed a plan to correct the deficiency; however, the citation remains at I.	01750		
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E and ULP-H)	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	11/14/2024

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FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

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01950	Continued From page 43 completed training and/or competency evaluations by a registered nurse (RN) for blood glucose testing. This resulted in an immediate correction order identified on November 13, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: ULP-E ULP-E was contracted through an outside nurse staffing agency and began providing assisted living services for the licensee on January 18, 2024. On November 12, 2024, beginning at 11:13 a.m., ULP-E was observed completing the following: - checked R4's phone and noted blood glucose results to be 107. ULP-E stated R4 does not get any insulin. ULP-E then administered oral medications and encouraged R4 to eat something for lunch since her blood glucose was 107. - checked R10's blood glucose results to be 140. ULP-E stated R10 does not get any insulin since the blood sugar was below 150. ULP-E's record contained a form titled, "[Agency name] Employee Check List" included facility information, how to use facility equipment, and fire information, and the bottom of the form included a section titled, "Sheets to Read and Go	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 44 Over" with an "X" in front of each of the following: - Blood Glucose Competency - Insulin Administration - Medication Administration The document was signed and dated by ULP-E on January 18, 2024. Included with this document was a blank Blood Glucose Competency form, a blank Insulin Administration form, and a blank Medication Administration form which included all routes of medication administration. ULP-E's file lacked evidence ULP-E had been trained or competency tested by the facility's RN prior to completing blood glucose testing. R4's medication administration record dated November 2024, indicated the following: - 8:00 a.m. Novolog Flexpen/Insulin Aspart (fast acting insulin) Administer insulin per sliding scale only HOLD IF BG [blood glucose] IS LESS THAN 150 BEFORE MEALS** SLIDING SCALE: 0 units: 0-150 2 units: 151-200 4 units: 201-250 6 units: 251-300 8 units: 301-350 10 units: 351-400 12 units: >401 - 11:30 a.m. Novolog Flexpen/Insulin Aspart (Daily) Administer insulin per sliding scale only SLIDING SCALE: 0 units: 0-150 2 units: 151-200 4 units: 201-250 6 units: 251-300 8 units: 301-350	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

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01950	Continued From page 45 10 units: 351-400 12 units: >401 - 4:45 p.m. Novolog Flexpen/Insulin Aspart (Daily) Administer insulin per sliding scale only SLIDING SCALE: 3 units: 0-150 5 units: 151-200 7 units: 201-250 9 units: 251-300 11 units: 301-350 13 units: 351-400 15 units: >401 R10's MAR dated November 2024, identified insulin aspart (Novolog) FlexPen ordered three times a day to be administered per sliding scale SLIDING SCALE: 0 units: 0-150 3 units: 151-199 6 units: 200-249 9 units: 250-299 12 units: 300-349 15 units: >350 R10's MAR further identified on November 12, 2024, at 8:00 a.m., R4's blood glucose was 174, and ULP-E administered 3 units of insulin. On November 12, 2024, at 12:56 p.m., ULP-E stated on her first day at the facility, the facility's unlicensed staff showed her around the facility, instructed her on what the residents' needs were, and how to use the electronic documentation system. The ULP staff showed her where the information for agency staff was kept in a folder and went through the checklist with ULP-E. ULP-E stated since she was a certified nursing assistant (CNA) and a trained medication aide (TMA), she knew what to do. The facility RN did	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 46 not train or competency test her prior to her completing blood glucose testing and other treatments to the residents. On November 13, 2024, at 12:46 a.m., assisted living director in residence/clinical nurse specialist (ALDIR/CNS)-A stated when agency staff come to the facility, they reviewed the [Agency name] Employee Check List form with another ULP. There was no place for the facility's staff to sign. ALDIR/CNS-A stated she does not do any treatment training or competency testing with the agency staff because they should have that completed through the agency. ALDIR/CNS-A stated she was unaware medication and treatment competencies were not transferable. ULP-H On November 13, 2024, ULP-H was observed completing the following: - at 8:14 a.m., checked R2's blood glucose. - at 8:38 a.m., checked R1's blood glucose. ULP-H was hired on October 9, 2023, to provide direct care services to the facility's residents. ULP-H's employee record indicated she was competency tested by the facility's RN for blood glucose testing on October 24, 2023. On November 13, 2024, at 8:42 a.m., ULP-H stated when she was trained, ULP-H initially completed the online training and then she trained with another ULP. On the first day, ULP-H observed the other staff; on the second day, ULP-H stated she did more hands on cares such as compression stockings, dressing, and oral medications; on the third day and subsequent days, ULP-H administered all routes of medications to include insulin, and also	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 47 completed blood glucose monitoring and other treatments. ULP-H was supervised by the other unlicensed staff. ULP-H stated the RN completed the training and competency testing after the online training and the training had been completed with the other ULP. On November 13, 2024, at 9:45 a.m., ALDIR/CNS-A stated staff initially complete the online training modules and then they train onsite with another ULP. Typically there are three training shifts where ALDIR/CNS-A checks to see how the ULP are doing and to see if they need more training or if they are doing well enough. ALDIR/CNS-A competency tested them at that time and then they are working independently. ULP observed for the first shift, start passing oral medications and helping with cares on the second shift, and then complete all medication routes and treatments including blood glucose testing by the third shift. Therefore, staff were completing those tasks prior to being competency tested by the RN. ALDIR/CNS-A stated she was unaware competency testing had to be completed prior to ULP completing blood glucose testing. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks Policy dated March 2020, indicated Qualifications for Unlicensed Personnel who Perform Delegated Nursing Tasks, Delegated Treatments or Assigned Therapy Tasks. A Registered Nurse may delegate nursing services, or an authorized Licensed Health Professional may delegate treatments or assign therapy tasks, to unlicensed personnel that: a. have successfully completed the training required for unlicensed personnel b. have been trained in the services to be provided,	01950		

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01950	Continued From page 48 c. have demonstrated to the RN or the Licensed Health Professional the ability to competently follow the procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 14, 2024, the licensee developed a plan to correct the deficiency; however, the citation remains at I.	01950		

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001
507-344-2700

Type: Full
Date: *11/13/24*
Time: 10:33:01
Report: 7990241004

Food and Beverage Establishment Inspection Report

Location:

Fieldcrest Assisted Living
80 Vermillion Street East
Cottonwood, MN56229
Lyon County, 42

Establishment Info:

ID #: 0038592
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074236691
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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

ECOLAB OASIS 137 IS NOT AN APPROVED SANITIZER, IT IS AN ALL PURPOSE CLEANER. UTILIZE PEROXIDE OR ECOLAB SINK AND SURFACE SANITIZERS ONSITE AS DISCUSSED WITH TOM.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE A TEST KIT FOR THE PEROXIDE SANITIZER AND THE SINK AND SURFACE SANITIZER. CURRENT QUATERNARY AMMONIA TEST KIT IS NOT APPLICABLE FOR THE SANITIZERS ONSITE.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = 170 at Degrees Fahrenheit
Location: HIGH TEMP DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: FRIGIDAIRE REACH IN HAM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: ARCTIC AIR REACH IN BEANS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: ARCTIC AIR REACH IN BUTTER
Violation Issued: No

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

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 7990241004 of 11/13/24.

Certified Food Protection Manager: Thomas L. Jackson

Certification Number: 67805 Expires: 12/08/26

Inspection report reviewed with person in charge and emailed.

Signed: Emailed
Establishment Representative

Signed: Beyn D. Dorh
7990

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

Report #: 7990241004

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001

No. of RF/PHI Categories Out	1	Date	11/13/24
No. of Repeat RF/PHI Categories Out	0	Time In	10:33:01
Legal Authority MN Rules Chapter 4626		Time Out	

Fieldcrest Assisted Living	Address: 80 Vermillion Street East	City/State: Cottonwood, MN	Zip Code: 56229	Telephone: 5074236691
License/Permit #: 0038592	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	X	
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		
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	X	
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) Emailed **Date:** 11/14/24

Inspector (Signature) Bryn D. Dorhi