Electronically Delivered

February 12, 2025

Licensee
Park Gardens of Fergus Falls
215 East Skogmo Boulevard
Fergus Falls, MN 56537

RE: Project Number(s) SL30541016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30541	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK GARDENS OF FERGUS FALLS	215 EAST SKOGMO BOULEVARD FERGUS FALLS, MN 56537

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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: SL30541016-0 On January 13, 2025, through January 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 62 residents; 58 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
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 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;	0 480		

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0 480	Continued From page 2 (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. 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 January 13, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of three employees (unlicensed personnel (ULP)-E).	0 650		

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0 650	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had a hire date of December 16, 2020, and began providing assisted living services to the licensee's residents on August 31, 2021. On January 13, 2025, at 11:35 a.m., the surveyor observed ULP-E administer R1's scheduled noon insulin. ULP-E's employee record lacked evidence ULP-E had documentation of annual performance reviews that defined areas of improvement needed and training needs. On January 16, 2025, at 10:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she does not have ULP-E's performance evaluation completed. LALD/CNS-A stated the licensee was short a cook; she was cooking for a while, so this put her behind on completing staff performance evaluations. The licensee's HR 201 Performance reviews policy revised on July 1, 2024, indicated the immediate supervisor will complete a performance evaluation at the end of the introductory period and annually thereafter. No further information was provided.	0 650		

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0 650	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to	0 780		

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0 780	Continued From page 6 the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 16, 2025, at 10:10 a.m., survey staff toured the facility with director of maintenance (DM)-G and it was observed that the emergency exit door, in the main-floor commons area, went out to the courtyard that did not have the snow removed, this removes a safe means of egress during a fire or similar emergency. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. These emergency exit doors were identified with overhead exit signs and are included in the facility's evacuation plan. DM-G verbally confirmed survey staff observation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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0 810	Continued From page 7	0 810		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 8 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 January 16, 2025, at 11:15 a.m., director of maintenance (DM)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Survey staff reviewed the fire evacuation diagrams and observed that they did not include where the emergency exits were located. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. DM-G stated they understood the areas of their policy that were incomplete and would work on	0 810		

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0 810	Continued From page 9 bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. DM-G stated training was done upon hire and once per year. Employee training content was provided by a third-party Relias and was not site specific. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. DM-G lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	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	01060		

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01060	Continued From page 10 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 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 written notice with required content to the resident, legal representative, and/or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4) who was hospitalized.	01060		

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01060	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and urinary retention. R4's Service Plan dated January 3, 2025, indicated R4 received assistance with dressing, grooming, showering, medication administration, toileting/incontinence cares, catheter cares, vital signs monitoring, housekeeping, and laundry. R4's progress notes indicated: - August 17, 2024, R4 sent to the emergency room following a fall, and was hospitalized for cardiac monitoring; - August 22, 2024, R4 was admitted to a transitional care unit for therapies; and - September 23, 2024, R4 returned to the facility. R4's record lacked evidence a written notice, including the following required content was provided to R4 or R4's representative or notification was provided to the Office of Ombudsman for Long-Term Care for R4's hospitalization of four days or longer: - 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;	01060		

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(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
01060	Continued From page 12 - 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 may submit an appeal. On January 16, 2025, at 9:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she usually does emergency relocation notices but missed doing this one for some reason. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290		

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	30541	A. BUILDING: _____ B. WING _____	01/16/2025

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01290	Continued From page 13 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the correct health facility identification (HFID) with the assisted living license for one of three employees (director of culinary (DC)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 13, 2025, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee record. DC-H was hired on November 2, 2023, and provided non-direct care services to residents. The licensee's NETStudy 2.0 Roster Report printed January 14, 2025, at 1:05 p.m., did not list DC-H as a current employee. DC-H's employee record contained a Department	01290		

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01290	Continued From page 14 of Human Services (DHS) background study clearance form dated November 2, 2023. The background study was affiliated to a sister facility with HFID 29188. DC-H's employee record lacked a cleared background study affiliated to the licensee. On January 14, 2025, at 1:40 p.m., LALD/CNS-A stated DC-H transferred from a sister location on June 6, 2024. LALD/CNS-A stated she never thought about needing to affiliate DC-H to the facility HFID and the only background study in his employee file was from HFID 29188. The licensee's undated Background Check Review Policy indicated all candidates are required to complete disclosure and authorization forms, authorizing [name] to conduct federal and state specific background checks. Upon return of successful background screenings and studies-candidate may be moved through onboarding process. [Name] will decline any new hire that is not cleared by state or federal study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 15 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for two of two residents (R1, R4) with a change in condition and failed to ensure a smoking assessment was completed for one of two residents (R8). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive).	01620		

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01620	Continued From page 16 The findings include: On January 13, 2025, at 10:30 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ongoing assessments were done every 90 days and change of condition assessments would be conducted on residents for instances such as hospital returns, change in services, or a change in condition. CHANGE IN CONDITION ASSESSMENT R1 R1's diagnosis included diabetes, hypertension (high blood pressure), and major depressive disorder. R1's service plan dated January 3, 2025, indicated R1 received assistance with medication administration, including insulin, blood glucose monitoring, behavior monitoring, continuous positive airway pressure (CPAP) management, monthly vital signs, housekeeping, and laundry. On January 13, 2025, at 11:35 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled noon insulin. R1's progress notes indicated the following: -October 31, 2024, at 4:27 p.m., written by licensed practical nurse (LPN), indicated R1's sister had taken R1 to the walk-in clinic due to a cough. -October 31, 2024, at 8:40 p.m., written by registered nurse, indicated diagnosis of pneumonia in right lower lobe. Started on antibiotics and decongestant. -November 5, 2024, at 10:32 p.m., written by on-call RN, indicated ULP reported blood glucose (blood sugar/BS) of 98 at 8:26 p.m., before dinner	01620		

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01620	Continued From page 17 and was given 4:00 p.m. insulin per parameters. ULP reported BS was 68 at 10:30 p.m., administered two glucose tablets, R1 reported no dizziness, shaking, increased confusion or decreased lack of consciousness. RN instructed ULP's check on her in 30-60 minutes. At 11:12 p.m., BS 92, and resident stated she felt dizzy, lightheaded, and terrible and requested to be sent to the hospital. -November 6, 2024, at 12:19 a.m., written by on-call RN, indicated R1 left facility to go to ER at 11:55 p.m. -November 6, 2025, at 6:53 a.m., written by on-call RN, indicated resident had returned and x-ray showed continued pneumonia. New antibiotic order. R1's record lacked a change of condition assessment after returning from walk in clinic visit with diagnosis of pneumonia. A change of condition assessment was not completed until November 6, 2025, six days after receiving her diagnosis of pneumonia. R4 R4's diagnoses included hypertension, atrial fibrillation (irregular heartbeat), and urinary retention. R4's service plan dated January 3, 2025, indicated R4 received assistance with dressing, compression stockings, catheter cares, toileting/incontinence cares, medication administration, monthly vital signs, housekeeping, and laundry. On January 14, 2025, at 7:30 a.m., the surveyor observed ULP-F administer R4's scheduled morning medications.	01620		

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01620	Continued From page 18 R4's progress notes indicated the following: - August 17, 2024, at 11:31 p.m., written by RN, indicated resident was sent to [facility] emergency room via ambulance for evaluation due to three falls in six hours. - August 19, 2024, at 1:23 p.m., written by RN, indicated resident was under observation in hospital, no pertinent findings, possible dehydration and monitoring cardiac status. No plan for discharge. - August 20, 2024, at 3:43 p.m., written by RN, indicated R4 remained at hospital under observation. Licensed social worker stated tentative plan was for R4 to discharge to a transitional care unit (TCU) for therapies and monitoring until she can return safely to apartment at assisted living facility (ALF). - August 22, 2024, at 12:03 p.m., written by RN, indicated resident was admitted to TCU for therapies. - September 23, 2024, at 10:40 a.m., written by RN, indicated R4 returned to the assisted living facility. Vitals taken, lungs clear, and resident had returned with a foley catheter. R4's record lacked a change of condition assessment after returning from a hospital and TCU stay. R4's change of condition assessment was completed on October 16, 2024, twenty-three days after returning from TCU. On January 15, 2025, at 2:35 p.m., LALD/CNS-A and RN-B stated a change of condition assessments were normally completed and was unsure why these were not done on R1 an R4. SMOKING ASSESSMENT R8's diagnosis included chronic pain syndrome, chronic kidney disease and depression.	01620		

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01620	Continued From page 19 R8's comprehensive nursing assessment dated January 10, 2025, indicated R8 had a history of smoking, however, did not address R8's ability to smoke without causing burns or injury to the resident or others or damage to property. On January 15, 2025, at 2:20 p.m., LALD/CNS-A and RN-B stated there was a smoking area outside on the left side of the building. RN-B stated two resident's smoke, R8 and R9. RN-B stated a smoking assessment was completed on R9, but not completed for R8. RN-B stated R8 had nicotine patches when she first moved in then started smoking again not too long ago and the smoking assessment was not yet completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R6). This practice resulted in a level two violation (a	02310		

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02310	Continued From page 20 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 14, 2025, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-J perform morning cares and use a hoyer lift (a mechanical device that assists residents with limited mobility) to transfer R6 from his bed to geri chair (a specialized recliner designed to help residents with limited mobility) and assist him to breakfast. On January 14, 2025, at 9:25 a.m., the surveyor observed a bottle of McKesson dermal wound cleanser and Remedy foam wound cleanser on R6's bedside table. ULP-J stated the registered nurse (RN), or hospice nurse takes care of wound care for R6. ULP-J placed the dermal wound cleanser into R6's locked medication cabinet, however, did not remove the foam dermal wound cleanser. On January 14, 2025, at 10:02 a.m., RN-B stated either the nurses here or the hospice nurses clean R6's wound and applied a Mepilex (foam dressing). RN-B observed and removed the foam wound cleanser from R6's bedside table. RN-B stated the wound cleansers should be locked in R6's locked medication cupboard and staff needed to be reeducated. The safety data sheet for McKesson dermal wound cleanser dated November 11, 2015,	02310		

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02310	Continued From page 21 indicated it may be harmful and to avoid inhalation, ingestion, or contact with eyes. The safety data sheet for Remedy foam dermal wound cleanser dated February 7, 2023, indicated it may be harmful and to avoid ingestion or contact with eyes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *01/13/25*
Time: 09:01:43
Report: 7935251003

Food and Beverage Establishment Inspection Report

Location:
Park Gardens Of Fergus Falls
215 East Skogmo Boulevard
Fergus Falls, MN56537
Otter Tail County, 56

Establishment Info:
ID #: 0037589
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189984444
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

SCOTT HAS TAKEN FOOD SAFETY CLASS. NEEDS TO SUBMIT AN APPLICATION FOR STATE CERTIFICATION. INFORMATION ON HOW TO OBTAIN CERTIFICATE EMAILED TO SCOTT.

Comply By: 02/28/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Walk In Cooler
Violation Issued: No

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

Type: Full
Date: *01/13/25*
Time: 09:01:43
Report: 7935251003
Park Gardens Of Fergus Falls

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 7935251003 of 01/13/25.

Certified Food Protection Manager: Scott Coykendall

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

Signed: _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us