October 3, 2023

Licensee
Cornerstone Villa
1000 Forest Street
Buhl, MN 55713

RE: Project Number(s) SL36627015

Dear Licensee:

On October 2, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 17, 2023, 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,

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

HHH

Electronically Delivered

August 31, 2023

Licensee
Cornerstone Villa
1000 Forest Street
Buhl, MN 55713

RE: Project Number(s) SL36627015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36627	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET BUHL, MN 55713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36627015-0 On August 15, 2023, through August 17, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 active residents receiving services under the Assisted Living license. An immediate correction order was identified on August 15, 2023, issued for SL36627015-0, tag identification 0470. On August 15, 2023, the immediacy of correction order 0470 was removed, however, non-compliance remained at a scope and level of F.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 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 1 (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 ensue direct care staff was available 24 hours a day, seven days a week who were responsible for responding to requests of residents for assistance. This had a potential to affect all 10 residents. This resulted in an immediate correction order issued on August 15, 203, at approximately 4:00 p.m.	0 470		

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0 470	Continued From page 2 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: The licensee had an assisted living license with a capacity of 10 beds. On August 15, 2023, at 10:08 a.m., during entrance conference, clinical nurse supervisor (CNS)-B stated the licensee staffed the assisted living facility with one unlicensed personnel (ULP) on days and one ULP on afternoons and utilized the staff from the attached care center to cover the night shift from 10:00 p.m., to 6:15 a.m. Licensed assisted living director (LALD)-A stated she had filed a variance to be able to utilize staff from the care center for the night shift and the variance had been denied. LALD-A stated she reapplied for the variance and but has not received a response back from the Minnesota Department of Health (MDH). The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated February, 23, 2023, indicated the licensee would be staffed with one unlicensed direct care staff per shift. Unlicensed staff may either be in the building, in an attached building, or within the campus and available. The UDALSA indicated the licensee provided assistance with dressing, grooming, bathing, one assist transfers, medication management, treatment and therapy	0 470		

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0 470	Continued From page 3 services, housekeeping and laundry. On August 15, 2023, at 1:25 p.m., LALD-A provided the surveyor with email correspondence with MDH which included: -August 30, 2022, at 9:10 a.m. LALD-A submitted an Assisted Living Licensure Rules Variance Request form to MDH. -October 13, 2022, at 11:48 p.m., MDH emailed LALD-A and informed the licensee's "new rule variance request" was denied and the information should be resubmitted on a new form as and innovation variance. MDH requested additional information from the licensee. -October 25, 2022, at 4:16 p.m., LALD-A emailed MDH additional requested information. -November 4, 2022, at 3:56 p.m., MDH emailed LALD-A an attached denial decision for the variance request. -November 8, 2022, at 12:09 p.m., LALD-A emailed MDH and requested additional information why the variance was denied. -November 9, 2022, at 3:54 p.m., MDH emailed LALD-A indicating MDH did not receive the licensee's innovation variance request form and requested a completed variance request form be submitted no later than Tuesday, November 15, 2022, for consideration. -November 9, 2022, at 4:42 p.m., LALD-A emailed MDH the innovative variance request form. The licensee's undated Staffing Assessment for	0 470		

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0 470	Continued From page 4 Assisted Living indicated, the licensee would staff one ULP for the day shift, one ULP for the afternoon shift per day and continue to the use staff from the care center for the night shift. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed as confirmed by evaluation supervisor review on August 15, 2023, however, non-compliance remains at a scope and level of two, widespread (F).	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required	0 550		

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0 550	Continued From page 5 information related to the grievance procedure. This had the potential to affect all current 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: On August 15, 2023, at 10:58 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B. The bulletin board by the main entrance of the assisted living had the Resident Grievance/Complaint Procedure form, dated January 2017, posted; however, the grievance procedure posted did not include the required content to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances; contact information for the state and applicable regional Office of Ombudsman for Long-Term Care Office of Ombudsman for Mental Health and Developmental Disabilities; and information for reporting suspected maltreatment to MAARC. CNS-B stated the above noted information was not included on the grievance procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

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0 650	Continued From page 6	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (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 interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (clinical nurse supervisor/CNS-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 650		

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0 650	Continued From page 7 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: CNS-B had a hire date of March 23, 2020, to provide and supervise direct care services to the licensee's residents. CNS-B's employee record contained a job description dated April 15, 2020, for an unlicensed personnel position; however, lacked a job description for current position. In addition, CNS-B's employee record lacked an annual performance review for 2022, identifying areas of improvement needed and training needs. On August 15, 2023, at 10:08 a.m., CNS-B stated she was aware of the required content for employee records and her and human resources maintained employee records. On August at 16, 2023, at 9:42 a.m., CNS-B stated she did not have an annual performance review in her employee record and further stated her last job description was from a different position in 2020, and never held a ULP position. Licensed assisted living director (LALD)-A stated they were behind on completing annual performance reviews for employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 8 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This	0 810		

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0 810	Continued From page 9 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). Findings include: A record review of available documentation and interview were conducted on August 16, 2023, at approximately 10:15 a.m. of documents provided by environmental services director (ESD)-G and licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that employee training was not documented indicating the required sequence of once at initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training is required to be documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. All deficiencies were verified by ESD-G and LALD-A during the interview. 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	01060		

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01060	Continued From page 11 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 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 for an emergency relocation to the resident, legal representative, or designated representative and additionally failed to notify the Office of Ombudsman for Long-Term Care of	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 resident relocation within four days for one of one resident (R6). 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: R6 was admitted to licensee on September 6, 2022. R6's Resident Notes dated October 2, 2022, indicated R6 went to the emergency department for evaluation post fall and was admitted for multiple right rib fractures and T6 (upper thoracic spine) compression fracture. R6's Resident Notes dated October 20, 2022, indicated R6 returned to the facility after a short term stay at a rehabilitation facility post rib and T6 fracture. R6's record lacked documentation R6 or R6's designated representative received an emergency relocation notice with all required content and further R6's record lacked documentation the Ombudsman was notified of R6's relocation of an overstay of four (4) days. On August 17, 2023, at 11:49 a.m., clinical nurse supervisor (CNS)-B stated a relocation written notice had not been provided to R6 or R6's representative and the Ombudsman had not	01060		

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	36627	A. BUILDING: _____ B. WING _____	08/17/2023

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01060	Continued From page 13 been notified of R6's relocation. CNS-B and licensed assisted living director (LALD)-A stated they were recently made aware of the requirement after the attached care center was surveyed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370		

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01370	Continued From page 14 licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two (unlicensed personnel (ULP)-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 August 15, 2023, at 10:08 a.m., clinical nurse supervisor (CNS)-B stated new employees were required to take all required training through CareAcademy (online education courses) and competency evaluations prior to working on the floor with another ULP.	01370		

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01370	Continued From page 15 ULP-H had a hire date of July 7, 2023, to provide direct care services under the assisted living license. R1 and R3's August medication administration summaries indicated on August 14, 2023, ULP-H provided medication and treatment services to R1 and R3. On August 16, 2023, at 2:43 p.m., CNS-B provided the surveyor ULP-H's employee record and stated she was now aware of what CareAcademy training were required and were missing from ULP-H's record. CNS-B stated ULP-H scheduled to work the afternoon shift and planned on having ULP-H work on completing the training. CNS-B verified ULP-H did not have all of the required training and competency evaluations completed before providing services to the residents. ULP-H's employee record lacked evidence ULP-H had received the following training and/or competencies: -appropriate and safe techniques in personal hygiene and grooming, including: hair care; care of teeth and gums; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy	01370		

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01370	Continued From page 16 dated February 3, 2023, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULPs shall include: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing; care of teeth, gums, and oral prosthetic devices; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; and - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 17 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two (unlicensed personnel (ULP)-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 August 15, 2023, at 10:08 a.m., clinical nurse supervisor (CNS)-B stated new employees were required to take all required training through CareAcademy (online education courses) and competency evaluations prior to working on the floor with another ULP. ULP-H had a hire date of July 7, 2023, to provide direct care services under the assisted living	01380		

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01380	Continued From page 18 license. R1 and R3's August medication administration summaries indicated on August 14, 2023, ULP-H provided medication and treatment services to R1 and R3. On August 16, 2023, at 2:43 p.m., CNS-B provided the surveyor ULP-H's employee record and stated she was now aware of what CareAcademy training were required and were missing from ULP-H's record. CNS-B stated ULP-H scheduled to work the afternoon shift and planned on having ULP-H work on completing the training. CNS-B verified ULP-H did not have all of the required training and competency evaluations completed before providing services to the residents. ULP-H's employee record lacked evidence ULP-H had received the following training and/or competencies: -recognizing physical, emotional, cognitive, and developmental needs of the client; and -range of motioning and positioning. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy dated February 3, 2023, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULPs shall include: - recognizing physical, emotional, cognitive, and developmental needs of the client	01380		

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01380	Continued From page 19 -range of motion and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	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	01470		

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01470	Continued From page 20 (9) a review of the types of assisted living 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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01470		

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01470	Continued From page 21 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: CNS-B CNS-B had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. CNS-B's employee record did not include the following training: -overview of Assisted Living 144 G statutes; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. ULP-D ULP-D had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. On August 16, 2023, at 6:56 a.m., the surveyor observed ULP-D administer R3's scheduled morning medications. ULP-D's employee record did not include the following training: -an overview of assisted living 144 G statues; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. ULP-H	01470		

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01470	Continued From page 22 ULP-H had a hire date of July 7, 2023, to provide direct care services under the assisted living license. ULP-H's employee record did not include the following training: -an overview of assisted living 144 G statues; -handing of resident complaints, reporting of complaints, where to report; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. On August 16, 2023, at 9:50 a.m., licensed assisted living director (LALD)-A and CNS-C reviewed employee records noted above with the surveyor and verified the missing required training. CNS-C stated the licensee was using CareAcademy online training program and staff were not being assigned the correct required training. The licensee's Orientation to Home Care Staff policy dated February 1, 2023, indicated all employees must complete the orientation to Assisted Living requirements before providing home care services to clients to include: -an overview of appropriate home care rules; -an introduction and review of all the provider's policies and procedures related to the provision of home care services; -a review of the 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	01470		

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01470	Continued From page 23 -a review of the types of home care services the employee will be providing and the provider's scope of home care license; and -staff providing Assisted Living services must be oriented specifically to each individual client and the services to be provided - this particular orientation topic may be provided in person, orally, in writing, or electronically. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 24 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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 employees received all of the required annual training content for each 12 months of employment for two of two employees (clinical nurse supervisor	01500		

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01500	Continued From page 25 (CNS)-B, unlicensed personnel (ULP)-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 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). The findings include: CNS-B CNS-B had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. CNS-B's employee record did not include the following annual training: -review of provider's policies and procedures. ULP-D ULP-D had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. On August 16, 2023, at 6:56 a.m., the surveyor observed ULP-D administer R3's scheduled morning medications. ULP-D's employee record did not include the following annual training: -infection control techniques; and -review of provider's policies and procedures. On August 16, 2023, at 9:50 a.m., licensed assisted living director (LALD)-A and CNS-C	01500		

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01500	Continued From page 26 reviewed employee training records with the surveyor and verified CNS-C and ULP-D's employee records lacked the noted above training for 2022. The licensee's Required Annual Staff Training policy dated February 1, 2023, indicated all staff of the licensee that performed direct Assisted Living services would complete a minimum of eight (8) hours of annual training for each 12 months of employment to include: - a review of infection control techniques used in the home and implementation of infection control standards including: -handwashing techniques; -the need for and use of protective gloves, gowns, and masks; -appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; -cleaning and disinfecting of reusable or shared equipment; -disinfecting environmental surfaces; and reporting of communicable diseases; and -a review of the home care provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36627	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE VILLA	1000 FOREST STREET BUHL, MN 55713

(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
01530	Continued From page 27 (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D), received the required two (2) hours of dementia care annual training. 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	01530		

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01530	Continued From page 28 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). The findings include: CNS-B CNS-B had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. ULP-D ULP-D had a hire date of March 23, 2020, and began providing assisted living services on August 1, 2021. On August 16, 2023, at 6:56 a.m., the surveyor observed ULP-D administer R3's scheduled morning medications. CNS-B's and ULP-D's employee records lacked evidence two (2) hours of annual dementia training was completed in 2022. On August 16, 2023, at 2:03 p.m., CNS-B and licensed assisted living director (LALD)-A reviewed CNS-B and ULP-D's employee records and stated there was no documentation CNS-B or ULP-D completed any dementia care training in 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services	01700		

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01700	Continued From page 29 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment to include self-medication administration for one of one resident (R1) who self-administered nasal spray. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01700		

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01700	Continued From page 30 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: R1's diagnoses included diabetes type 2, mild cognitive impairment, history of epistaxis (bloody nose), congested heart failure, pulmonary disease, and age-related macular degeneration (disease of the eye that causes vision loss). On May 24, 2023, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-D enter R1's room and administer R1's eye drops and oral medications. ULP-D handed R1 a bottle of Deep Sea nasal spray and R1 consecutively administered two sprays of the medication into each nostril then handed ULP-D the nasal spray. R1's Service Plan dated June 2, 2023, indicated R1 received medication administration services. R1's Individualized Medication Management Plan dated August 7, 2023, indicted a self-medication assessment was not completed and R1 chose to have medications managed and administered by the licensee. R1's prescriber orders dated July 21, 2023, included deep sea nasal spray 0.65 % instill two (2) sprays into each nostril twice a day for history of epistaxis. R1's August Medication Administration Summary did not indicate R1 was able to self-administer own nasal spray.	01700		

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01700	Continued From page 31 R1's record lacked a self-medication assessment to determine R1 was able to self-administer own nasal spray correctly and safely. On August 16, 2023, at 9:52 a.m., clinical nurse supervisor (CNS)-B stated R1 did not have a medication assessment completed to administer own nasal spray. CNS-B stated it was her understanding if staff were supervising and available to instruct the resident on proper use during the administration a self-medication administration assessment was not required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01770		

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01770	Continued From page 32 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 entrance conference on August 15, 2023, at 10:08 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services including medication set up. R5's diagnoses included macular degeneration (eye disease which causes vision loss), hyperlipidemia (high cholesterol), chronic kidney disease, depressive disorder, and hypertension (high blood pressure). R5's Service Plan dated May 3, 2023, indicated R5 received medication administration which included medication set weekly by the registered nurse. R5's comprehensive assessment dated June 13, 2023, indicated the licensed nurse was to set up medications on a weekly basis in a pill box and document medications set up. R5's prescriber orders dated July 7, 2023, included the following medications: -amlodipine five (5) milligrams (mg) one (1) tablet daily for high blood pressure; -aspirin 81 mg one (1) tablet daily for hear health; and -senna plus 50 mg-8.6 mg one (1) tablet daily on Tuesday, Thursday, Saturday, Sunday and two (2) tablets Monday, Wednesday and Friday for constipation.	01770		

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01770	Continued From page 33 R5's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup in R5's record. On August 17, 2023, at 8:45 a.m., CNS-B stated documentation of R5's medication set up was listed on the back of R5's medication planner. CNS-B provided the surveyor a photocopy of the back of R5's medication planner which included a typed piece of paper tapped to the back of the planner with R5's name, medications, dose, and times to be administered. CNS-B stated R5's medication set up documentation did not include dates the medications were set up or route of administration and was unaware of the required content. Further, CNS-B stated the medication set up documentation on the back of R5's medication planner was not a part of R5's record. The licensee's Medication Administration Weekly Dosage Box Set Up dated April 2020, indicated when the licensed nurse completed setting up the medications into the dosage box, the set up would be documented on the medical administration record (MAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 34 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the	01790		

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01790	Continued From page 35 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures with all the required content for unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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:	01790		

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01790	Continued From page 36 On August 15, 2023, at 10:08 a.m., during entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to include unplanned time away. CNS-B stated ULPs were trained to prepare and send medications with residents for unplanned times away when the nurse was unavailable. The surveyor requested a copy of the licensee's policy and procedure for unplanned time away. On August 16, 2023, at 9:38 pm., CNS-B provided the surveyor with the licensee's Medication Administration-Planned and Unplanned Time Away policy. CNS-B stated she was unaware if there was a written procedure for unplanned time away ant the procedure was covered during orientation training. The licensee's Medication Administration - Planned and Unplanned Time Away policy dated August 1, 2022, indicated an Assisted Living provider who is providing medication management services to the the client and controls the client's access to the medication must develop and implement policies and procedures for giving accurate and current medications to clients for unplanned times away form home (up to five days) according to the client's individualized medication management plan. For unplanned time away when a licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel. The registered nurse would develop written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that were prescribed for the client. The written procedure must address:	01790		

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01790	Continued From page 37 - the type of container or containers to be used for the medications appropriate to the provider's medication system; a med planner or labeled pill pouch; - how the container or containers must be labeled; with the name of the client and the date and time for administration; - written information about the medications to given to the client or client's representative; printed out off of Rtaks as "meds sent out of facility"; - how the unlicensed staff must document in the resident's record that medications have been given to the client or client's representative, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN shall be notified that medications have been given to the client or client's representative and whether the RN needs to be contacted before the medications are given to the client or the client's representative; and contact the RN ahead of time via phone. The licensee's policy and procedure lacked a procedure to include: -a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. No further information was provided.	01790		

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01790	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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

Type: Full
Date: *08/15/23*
Time: 22:35:00
Report: 7983231130

Food and Beverage Establishment Inspection Report

Location:
Cornerstone Villa
1000 Forest Street
Buhl, MN55713
St. Louis County, 69

Establishment Info:
ID #: 0039145
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182583253
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Warewashing Machine
Temperature: 150 Degrees Fahrenheit - Location: Final sanitary rinse of the Bosch NSF 184 residential warewashing machine.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 41 Degrees Fahrenheit - Location: Air temperature of the refrigerator compartment of the GE refrigerator/freezer.
Violation Issued: No

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

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

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GENERAL COMMENTS:

1) Meals are prepared in the skilled nursing kitchen. They are transported portioned on trays via a wheeled Cambro insulated cart to the assisted living dining area.

2) Recommend to pre-chill cold sandwich and pasta-type salad ingredients and to make sure that hot holding and cold holding temperatures are met before transporting the meals to the assisted living

residents.

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 7983231130 of 08/15/23.

Certified Food Protection Manager: N/A

Certification Number: N/A Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sara Nygard
Assisted Living Manager

Signed: 7983

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