



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 7, 2023

Licensee
Grand Arbor
4403 Pioneer Road Southeast
Alexandria, MN 56308

RE: Project Number(s) SL30805015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 22, 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: jess.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: SL30805015-0</p> <p>On June 20, 2023, through June 22, 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 83 active residents whom were receiving services under the Assisted Living with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the</p>	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
0 480	<p>Continued From page 1</p> <p>following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 20, 2023, for the specific Minnesota Food Code deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 480		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
0 800	<p>Continued From page 2</p> <p>residents in accordance with a maintenance and repair program.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 the potential to affect a large portion or all residents).</p> <p>The findings include:</p> <p>On June 20, 2022, from approximately 1:30 p.m. to 2:45 p.m., survey staff toured the facility with Maintenance (M)-H. During the facility tour, survey staff observed and verified the following maintenance issues:</p> <ol style="list-style-type: none"> 1. The fire rated doors in Prairie North and Enhanced assisted living laundry rooms were propped open with a door wedge. 2. Trash chute door in the lower level, South and Center room, was missing the fusible link which will alter the function to close as designed when there is a fire. <p>M-H verbally confirmed survey staff observations during the facility tour.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
0 800	Continued From page 3 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for two of four employees (unlicensed personnel/ULP-D, ULP-G). 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	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01290	<p>Continued From page 4</p> <p>or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>ULP-D ULP-D was hired on September 2, 2013, to provide direct care services to the facility's residents and continued providing care after August 1, 2021 under the assisted living license.</p> <p>ULP-D's record lacked documentation of a background study affiliated with the facility's license.</p> <p>On June 21, 2023 at 7:55 a.m., the surveyor observed ULP-D provide morning cares to include incontinence cares, grooming, and dressing to resident (R1). At 8:31 a.m., the surveyor observed ULP-D administer R1's morning medications.</p> <p>ULP-G ULP-G was hired on August 5, 2019, to provide direct care services to the facility's residents and continued providing care after August 1, 2021, under the assisted living license.</p> <p>On June 21, 2023, at 7:18 a.m., the surveyor observed ULP-G provide morning cares to include incontinence care, grooming, dressing and transfer R4 with a Hoyer (mechanical lift utilizing a body sling). At 7:19 a.m., the surveyor observed ULP-G administer R3's scheduled morning insulin.</p> <p>ULP-D and ULP-G's record lacked documentation of a background study affiliated with the facility's license.</p>	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01290	Continued From page 5 On June 21, 2023, at 2:57 p.m., licensed assisted living director (LALD)-A stated he had reviewed the background studies with the facility Human Resources department and verified ULP-D and ULP-G's background studies were not affiliated with the facility's license. LALD-A stated the background studies had been completed under NetStudy 1.0 and when the facility licensure transitioned and NetStudy transitioned to 2.0, ULP-D and ULP-G's backgrounds did not transition over. Additionally, LALD-A stated, "we are getting those corrected right now". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	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 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	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01620	<p>Continued From page 6</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of four residents (R5) with a change in condition.</p> <p>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).</p> <p>The findings include:</p> <p>R5's diagnosis included Alzhiemers disease.</p> <p>R5's Service Plan, dated May 23, 2023, indicated services to include bathing/shower assistance, oral cares, dressing, grooming, toileting, ambulation assist, feeding, medication administration, housekeeping, and laundry.</p> <p>R5's most recent assessment was completed on May 23, 2023.</p> <p>On June 21, 2023, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-G provide morning cares and remove heel protector boots</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01620	<p>Continued From page 7</p> <p>from R5's feet. ULP-G stated registered nurses (RN) provided the training for specialized items and R5 had used the heel protectors "when she was on hospice".</p> <p>On June 21, 2023, at 11:37 a.m., the surveyor and clinical nurse supervisor (CNS)-B reviewed R5's service plan, assessments, prescriber's orders and progress notes.</p> <p>R5's record and/or assessment did not include heel protection boots.</p> <p>On June 21, 2023, at approximately 11:45 a.m., CNS-B stated assessments were expected to be completed with changes of condition and include any special items used by the resident. Additionally, CNS-B stated R5 had graduated off hospice cares in April 2023 and the heel protectors must have been continued to be used by staff after R5's transition in cares, however, "the staff shouldn't have been using them if it wasn't on the plan of care".</p> <p>The licensee's Initial, and On-Going Nursing Assessment policy dated October 27, 2021, indicated the RN would reassess the resident and update the assessment and service plan based on the required assessment schedule and as needed based on the residents condition. The licensee's policy indicated assistive devices would be included in reassessments.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01760 01760 SS=D	<p>Continued From page 8</p> <p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to the pharmacy recommendation for one of five residents (R3).</p> <p>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 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).</p> <p>The findings include:</p> <p>R10's lorazepam concentrate two (2) milligram (mg)/milliliter (ml), was administered after the medication was expired.</p>	01760 01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01760	<p>Continued From page 9</p> <p>R10's diagnoses included dementia (memory loss), hypertension (high blood pressure) and epilepsy (a neurological disorder).</p> <p>R10's Service Plan dated June 19, 2023, indicated R10 received medication management services, including medication administration.</p> <p>R10's prescriber orders dated as follows included: - December 22, 2022, lorazepam concentrate 2 mg/ml, give 0.25 ml orally every three (3) hours as needed for agitation/anxiety, and; - February 5, 2023, lorazepam concentrate 2 mg/ml, give one (1) ml orally with seizure activity. May repeat up to four (4) times, (eight (8) mg total).</p> <p>R10's May 2023, electronic medication administration record (EMAR) indicated resident received the following medications: - May 15, 2023, at 2:00 p.m., lorazepam concentrate 2 mg/ml, give 0.25ml orally every three (3) hours as needed for agitation/anxiety. Call nurse before administering. - May 24, 2023, at 10:37 a.m., lorazepam concentrate 2 mg/ml, give one (1) ml orally with seizure activity. May repeat up to four times (eight (8) mg total). Call nurse before administering.</p> <p>On June 20, 2023, at 2:27 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed the medication refrigerator on Prairie North (secured unit), inside the locked refrigerator was a clear box labeled with R10's name and contained two (2) set-up syringes of each dose. The syringes were labeled as follows: - [R10's name] lorazepam concentrate 2 mg/ml, give 0.25ml orally every three (3) hours as</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023	
NAME OF PROVIDER OR SUPPLIER GRAND ARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308		
(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
01760	<p>Continued From page 10</p> <p>needed for agitation/anxiety. Call nurse before administering. Expires April 19, 2023.</p> <p>- [R10's name] lorazepam concentrate 2 mg/ml, give one (1) ml orally with seizure activity. May repeat up to four (4) times (eight (8) mg total). Call nurse before administering. Expires May 9, 2023.</p> <p>On June 20, 2023, at 2:30 p.m., CNS-B stated the licensed practical nurses (LPN's) draw the liquid lorazepam doses into the syringes from the original container. She was unsure why the LPN's did not dispose of the expired medications and set-up new ones. She stated the pharmacy was consulted for the shelf life of liquid lorazepam once removed from the original container. CNS-B removed the syringes and stated the medications will be destroyed.</p> <p>On June 22, 2023, at 11:15 a.m., CNS-B stated R3 received two doses of the liquid medication in May 2023, and it was likely the medications were administered past the expiration date on the individual syringes.</p> <p>The licensee's Medication Management Services policy dated October 28, 2022, indicated the registered nurse (RN) or licensed practical nurse (LPN) would review prescribed medications to identify any contraindications or other concerns and if the nurse identified any discrepancies or concerns when setting up medications, the nurse would complete appropriate follow up.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01890	Continued From page 11	01890		
01890 SS=F	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for five of five residents (R5, R10, R12, R13, R14), and failed to ensure time sensitive medications were labeled with open and expiration dates per manufacturer instructions for three of three residents (R11, R15, R16). Additionally, the licensee failed to ensure an original pharmacy label was on a medication for one of three residents (R16).</p> <p>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).</p> <p>The findings include:</p> <p>On June 20, 2023, at 2:39 p.m., the surveyor and clinical nurse supervisor (CNS)- B, observed medications secured in the locked medication refrigerators and medication carts. CNS-B stated the licensed practical nurses (LPN's) draw the liquid medication doses into the syringes from the</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01890	<p>Continued From page 12</p> <p>original medication container. CNS-B was unsure why the LPN's did not dispose of the expired medications and set-up new syringes. She stated the pharmacy was consulted for the shelf life of the liquid medications once drawn from the original container. CNS-B removed the syringes and stated the medications would be destroyed. CNS-B confirmed the following expired medications were available for staff to administer to the residents.</p> <p>EXPIRED MEDICATIONS</p> <p>R5 R5's morphine sulfate concentrate, 20 milligram (mg)/milliliter (ml), give 0.5 ml by mouth at bedtime for pain. Call a nurse before administering. Expires June 9, 2023. Two (2) labeled pre-set up syringes.</p> <p>R5's morphine sulfate concentrate, 20 mg/ml, give 0.5 ml by mouth every two (2) hours as needed for pain or shortness of breath. Call nurse before administering. Expires June 12, 2023. 2 labeled pre-set up syringes.</p> <p>R10 R10's lorazepam concentrate, 2 mg/ml, give 0.25 ml orally every three (3) hours as needed for agitation/anxiety. Call nurse before administering. Expires April 19, 2023. 2 labeled pre-set up syringes.</p> <p>R10's lorazepam concentrate, 2 mg/ml, give one (1) ml orally with seizure activity. May repeat up to four (4) times eight (8) mg. Call nurse before administering. Expires May 9, 2023. 2 labeled pre-set up syringes.</p> <p>R12</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01890	<p>Continued From page 13</p> <p>R12's morphine sulfate concentrate, 20 mg/5 ml, give 0.25 ml by mouth every 4 hours as needed for pain. Expires June 17, 2023. 2 labeled pre-set up syringes.</p> <p>R13 R13's morphine sulfate concentrate, 20 mg/ml, give 0.25 ml by mouth every 4 hours as needed for pain or shortness of breath. Expires June 17, 2023. 2 labeled pre-set up syringes.</p> <p>R14 R14's lorazepam concentrate, 2 mg/ml, give 0.25 ml orally every 3 hours as needed for agitation/anxiety. Call nurse before administering. Expires May 9, 2023. Six (6) labeled pre-set up syringes.</p> <p>R14's morphine sulfate concentrate, 20 mg/ml, give 0.25 ml by mouth every 4 hours as needed for pain or difficulty breathing. Expires June 17, 2023. 2 labeled pre-set up syringes.</p> <p>TIME SENSITIVE MEDICATIONS</p> <p>R11 R11's Lantanaprost solution 0.005% (glaucoma medication) lacked a label to indicate when the eye drop solution was opened and when the solution would expire.</p> <p>R15 R15's Lantanaprost solution 0.005% (glaucoma medication) lacked a label to indicate when the eye drop solution was opened and when the solution would expire.</p> <p>R16 R16's Timolol Maleate solution 0.5% (glaucoma medication) lacked an original pharmacy label</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
01890	<p>Continued From page 14</p> <p>and a label to indicate when the eye drop solution was opened and when the solution would expire.</p> <p>The manufacturer instructions for Latanoprost solution dated January 2019 indicated to throw out any remaining solution after four weeks from the date of opening.</p> <p>The manufacturer instructions for Timolol Maleate solution dated February 2020 indicated to discard the bottle 28 days after opening, even if there is solution remaining.</p> <p>On June 22, 2023, at 10:45 a.m., CNS-B stated eyedrop medications should have original pharmacy labels and be labeled with open and expiration dates.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		
02310 SS=F	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure safe oxygen storage, according to acceptable health care, medical, or nursing standards for two of two residents (R9, R7).</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
02310	<p>Continued From page 15</p> <p>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 the potential to affect a large portion or all of the residents. In addition, widespread may be identified if a systemic failure would be likely to affect a large number of residents and is, therefore, pervasive in the facility).</p> <p>The findings include:</p> <p>The licensee failed to ensure oxygen cylinders was secured in a well-ventilated area and in a stand or a cart to prevent the cylinder from being knocked over or damaged. In addition, the licensee failed to post oxygen signs on residents doors.</p> <p>R9 R9's diagnoses included dementia (memory loss), and hypertension (high blood pressure).</p> <p>R9's record indicated R9 used oxygen at one (1) liter per minute (LPM) via nasal cannula as needed.</p> <p>On June 21, 2023, at 8:35 a.m., the surveyor and unlicensed personnel (ULP)-D observed six (6) secured and two (2) unsecured oxygen tanks inside a closet. In addition, the resident's door lacked an oxygen sign. ULP-D stated the resident doesn't normally have this many tanks, and the tanks should be secured.</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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
02310	<p>Continued From page 16</p> <p>R7 R7's diagnoses included dementia (memory loss), and chronic obstructive pulmonary disease (constriction of the airways making it difficult to breathe).</p> <p>R7's record indicated R7 used oxygen at two (2) LPM per nasal cannula at night and as needed.</p> <p>On June 21, 2023, at 8:40 a.m., the surveyor and ULP-D observed three (3) secured oxygen cylinders on the floor against a wall in the kitchen, and one (1) oxygen cylinder laying on its side in a canvas bag on the counter. ULP-D stated the tank should be upright and secured. In addition, the resident's door lacked an oxygen sign.</p> <p>On June 21, 2023, at 8:45 a.m., the surveyor and registered nurse care coordinator (RNCC)-I observed R7 and R9's unsecured tanks. RNCC-I stated all oxygen cylinders should be secured and oxygen signs should be on the doors if a resident has oxygen.</p> <p>The licensee's Safe Oxygen Use and Storage policy revised on December 3, 2021, indicated oxygen containers must be stored in a well-ventilated area, and should not be kept under a bed, in a small area such as a closet or cabinet or covered by linens or clothing. In addition, oxygen containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage and must not be located in area where they may be overturned due to a door opening or where they may be in a pathway.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GRAND ARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4403 PIONEER ROAD SE ALEXANDRIA, MN 56308
--	---

(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



Type: Full
Date: 06/20/23
Time: 10:30:49
Report: 1008231006

Food and Beverage Establishment Inspection Report

Location:

Grand Arbor
4403 Pioneer Road Se
Alexandria, MN56308
Douglas County, 21

Establishment Info:

ID #: 0038446
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207631600
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.13

**** Priority 1 ****

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

half package of unpasteurized eggs in bottom prep cooler. Staff unaware of how these eggs are used within kitchen. chef base contains working stock of approved pasteurized eggs.

Comply By: 06/21/23

4-500 Equipment Maintenance and Operation

4-501.114C3

**** Priority 1 ****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Sanitizer bucket on grill line had 0 concentration of quaternary ammonium. Bucket was refilled with a concentration of 300 ppm.

Corrected on Site

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

food item containers within the freezer on the grill line shall have the common name of the food item.

Type: Full
Date: 06/20/23
Time: 10:30:49
Report: 1008231006
Grand Arbor

Food and Beverage Establishment Inspection Report

Comply By: 06/22/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

discontinue to store TCS foods in the satellite kitchens for 24 hours or longer.

Comply By: 06/22/23

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

currently no thermometers are located within the chef base coolers. Provide thermometers in the chef base coolers.

Comply By: 06/22/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

repair what the problem is with the type 2 ventilation hood above the dish machine. Wood boards are nailed up under the hood around the vent opening.

Comply By: 06/27/23

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit

Location: Dish machine

Violation Issued: No

Quaternary Ammonia: = 0 at Degrees Fahrenheit

Location: Sanitizer bucket on grill line

Violation Issued: Yes

Quaternary Ammonia: = 300 at Degrees Fahrenheit

Location: Sanitizer bucket on grill line

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler - Top

Temperature: 41 Degrees Fahrenheit - Location: cole slaw

Violation Issued: No

Type: Full
Date: 06/20/23
Time: 10:30:49
Report: 1008231006
Grand Arbor

Food and Beverage Establishment Inspection Report

Process/Item: Chef Base Cooler
Temperature: 41 Degrees Fahrenheit - Location: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: chicken noodle soup
Violation Issued: No

Process/Item: Prep Cooler - Top
Temperature: 41 Degrees Fahrenheit - Location: salsa
Violation Issued: No

Process/Item: Prep Cooler - Top
Temperature: 41 Degrees Fahrenheit - Location: hard boiled egg
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: taco meat
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	0	4

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

Type: Full
Date: 06/20/23
Time: 10:30:49
Report: 1008231006
Grand Arbor

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 Minnesota Department of Health inspection report number 1008231006 of 06/20/23.

Certified Food Protection Manager: Ariel A Chalmers

Certification Number: FM116185 Expires: 01/31/26

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1008

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us