DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

January 22, 2024

Licensee
Americare Lodges
20371 Wendigo Park Road Bldg 3
Grand Rapids, MN  55744

RE: Project Number(s) SL36294015

Dear Licensee:

On January 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 9, 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

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

PMB

DEPARTMENT OF HEALTH

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November 2, 2023

Licensee
Americare Lodges
20371 Wendigo Park Road, Building 3
Grand Rapids, MN  55744

RE:  Project Number(s) SL36294015

Dear Licensee:

On October 16, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 9, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 9, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 9, 2023, found not corrected at the time of the October 16, 2023, follow-up survey and/or subject to penalty assessment are as follows:

**0770-Minimum Site Requirements-144g.45 Subdivision 1**
**0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)**
**0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)**
**0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)**
**1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)**

The details of the violations noted at the time of this follow-up survey completed on October 16, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

**DOCUMENTATION OF ACTION TO COMPLY**

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

**IMPOSITION OF FINES:**

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

**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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at .

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

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36294 | A. BUILDING: _____ B. WING _____ | R 10/16/2023 |

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| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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| {0 000} | Initial Comments<br><br>*****ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been 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.<br><br>INITIAL COMMENTS:<br>SL36294015-1<br><br>On October 16, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 9, 2023. At the time of the survey, there were 20 active residents receiving services under the Assisted Living license. As a result of the revisit, orders 0770, 0800, 0810, 0820 and 1620 were reissued. | {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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| {0 770} SS=C | 144G.45 Subdivision 1 Minimum site Requirements<br><br>The following are required for all assisted living | {0 770} | | |

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| {0 770} | Continued From page 1<br><br>facilities:<br>(1) public utilities must be available, and working or inspected and approved water and septic systems must be in place;<br>(2) the location must be publicly accessible to fire department services and emergency medical services;<br>(3) the location's topography must provide sufficient natural drainage and is not subject to flooding;<br>(4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and<br>(5) the location must include space for outdoor activities for residents.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to test the well water within the last year. This had the potential to directly affect all residents and staff.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings:<br><br>A record review of available documentation and interview were conducted on October 16, 2023, at approximately 11:00 a.m. of documents provided by licensed assisted living director in residence (LALDIR)-A and clinical nurse supervisor | {0 770} | | |

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| {0 770} | Continued From page 2<br>(CNS)-B.<br><br>There was no current water well test documentation available for review for building #1, #3 and #4 at the time of interview. Domestic well water is required to be tested annually.<br><br>This deficiency was verified by LALDIR-A and CNS-B during the interview. | {0 770} | | |
| {0 800} SS=C | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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 residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's 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.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). | {0 800} | | |

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| {0 800} | Continued From page 3<br><br>Findings include:<br><br>On a facility tour on October 16, 2023, at approximately 10:30 a.m. with clinical nurse supervisor (CNS)-B it was observed that siding was loose and damaged at ground level on the front of building #4. Exterior finish material is required to be maintained as designed and installed at the time of construction.<br><br>These deficient conditions were visually verified by CNS-B accompanying on the tour. | {0 800} | | |
| {0 810} SS=C | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the | {0 810} | | |

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| {0 810} | Continued From page 4<br><br>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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>A record review of available documentation and interview were conducted on October 16, 2023, at approximately 11:45 a.m. of documents provided by licensed assisted living director in residence (LALDIR)-A and clinical nurse supervisor (CNS)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Findings include: | {0 810} | | |

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| {0 810} | Continued From page 5<br><br>Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation.<br><br>Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for these facilities and buildings located within the plan.<br><br>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan.<br><br>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.<br><br>Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan.<br><br>Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are | {0 810} | | |

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| {0 810} | Continued From page 6<br><br>capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. LALDIR-A indicated the resident training is provided along with employee training but was not documented.<br><br>Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required.<br><br>All deficiencies were verified by LALDIR-A and CNS-B during the interview. | {0 810} | | |
| {0 820} SS=C | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. | {0 820} | | |

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| {0 820} | Continued From page 7<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>Findings include:<br><br>On a facility tour on October 16, 2023, at approximately 11:00 a.m. with clinical nurse supervisor (CNS)-B, it was observed the exterior gate from the fenced outdoor patio area of building #3 was off the hinges and had vegetation growing around it so it could not be opened. Gates or doors in the exterior exit path to the public way are required to operate the same as the building exterior exit doors and be maintained as operable at all times for exiting in the event of a fire or similar emergency.<br><br>This deficient condition was verified by CNS-B accompanying on the tour. | {0 820} | | |
| {01620} SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an | {01620} | | |

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| {01620} | Continued From page 8<br><br>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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment by a registered nurse (RN) for two of two residents (R15, R1) with falls and a change of condition to include addition of hospice services.<br><br>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).<br><br>The findings include:<br><br>FALLS<br>R15 was admitted to the facility on August 31, 2023. | {01620} | | |

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| {01620} | Continued From page 9<br><br>R15's diagnoses included below the knee amputation, dementia and hypertension (elevated blood pressure).<br><br>R15's service plan dated October 9, 2023, indicated R15 received services to include bathing, dressing, grooming, escort/mobility assistance, toileting, transfer assist, meal assistance, medication administration, safety checks, housekeeping, and laundry.<br><br>R15's 14-day nursing assessment dated September 5, 2023, indicated R15 had an amputation of the left lower leg, experienced problems with walking and standing, was at risk for dehydration, incontinent of bowel and bladder, had impaired judgement and poor problem solving skills, experienced mood swings and anxiety, and an inability to relax with poor concentration. Additionally, the assessment indicated R15 was at risk for falls related to overall health and diagnoses.<br><br>R15's record indicated five (5) falls were noted during a 21 day period, on the following dates;<br>- August 31, 2023, written by clinical nurse supervisor (CNS)-B: this writer notified by staff that resident had fallen. Resident stated that he only hit his head slightly.<br>- September 4, 2023, CNS-B wrote: writer notified by on-call licensed practical nurse (LPN) manager that resident had a fall this morning. Resident stated that he did not hit his head and was not hurt.<br>- September 4, 2023, unlicensed personnel (ULP) wrote: Resident found lying on floor. Resident stated he was trying to self-transfer and fell to the ground. Resident stated he wasn't hurt and did not hit head. No complaints of pain. Writer | {01620} | | |

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| {01620} | Continued From page 10<br><br>noticed a scrape on right elbow, cleaned area, triple antibiotic ointment applied and bandaged.<br>- September 7, 2023, CNS-B wrote: writer notified via phone call resident was found lying on floor in his bathroom. Resident stated he was trying to self-transfer and fell to the ground. Resident stated he was not hurt and did not hit head.<br>- September 14, 2023, CNS-B wrote: writer notified that resident had a fall around 2:45 a.m., he sustained a small laceration above his right eye, no complaints of pain. They [ULP's] were able to steri-strip area together and place bandaid on the site.<br>- September 23, 2023, CNS-B wrote: this writer was updated by on-call LPN that resident had fallen. No injuries noted. Resident stated that he did not hit his head.<br><br>R15's record lacked a reassessment completed by a registered nurse (RN) to address falls, including lack of developing individualized fall prevention interventions with the exception of adding safety checks on October 6, 2023.<br><br>CHANGE IN CONDITION<br>R1 was admitted to the facility on December 8, 2022, and was placed on hospice services September 25, 2023.<br><br>R1's diagnoses included dementia and chronic obstructive pulmonary disease (COPD).<br><br>R1's unsigned service plan dated October 2, 2023, indicated R1 received services to include bathing, dressing, grooming, escort/mobility assistance, toileting, transfer assist, meal assistance, medication administration, oxygen and nebulizer assistance, safety checks, housekeeping, and laundry. | {01620} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36294 | A. BUILDING: _____ B. WING _____ | R 10/16/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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| {01620} | Continued From page 11<br><br>R1's last 90-day nursing assessment dated September 18, 2023, indicated R1 had poor decision making skills, memory problems, had sexually and socially inappropriate behaviors, impaired judgement, a history of alcohol dependency, falls and was oxygen dependent.<br><br>R1's progress notes dated September 1, 2023, through October 16, 2023, indicated R1 had changes in condition as follows:<br>- on September 19, 2023, at 12:28 p.m., a LPN wrote: resident has shortness of breath (SOB) even with oxygen at 3 liters per minute (LPM) via nasal cannula. 98% on 3 liters. Resident has 3+ pitting edema bilateral lower extremities. Resident has "crud" in lungs either rales or ronchi. Updated RN and will be sent in.<br>- on September 19, 2023, at 12:41 p.m., CNS-B wrote: writer was contacted by staff working in house three and stated resident seemed to have severe SOB. (CNS-B conducted a focused assessment) notified R1's family and called 911 for transport. R1 declined to be seen at the emergency room for an evaluation. CNS-B placed R1 on a list of residents to be seen the next day (September 20, 2023) by the rounding nurse practitioner (NP).<br>- on September 20, 2023, at 2:16 p.m., CNS-B wrote: resident was seen by rounding NP regarding recent change of condition. Increase Furosemide 40 milligram (mg) tablet once daily to 40 mg tablet twice daily. The second dose not to be given past 2:00 p.m. Provider discussed with resident potentially being referred to Hospice for comfort focused cares and not needing to be sent into the emergency room. Resident was open to this, referral made to [hospice agency name] hospice. Nothing else new at this time.<br>- on September 20, 2023, at 9:21 p.m., CNS-B wrote: writer notified by staff working in house | {01620} | | |

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| {01620} | Continued From page 12<br><br>three (3) resident fell. Resident stated he did not hit his head. Resident seemed to have increased weakness.<br>- on October 1, 2023, at 8:56 p.m., CNS-B wrote: writer was speaking with staff member regarding another resident when staff advised writer resident had fallen in his room. Resident denied hitting his head.<br>- on October 8, 2023, at 5:51 p.m., CNS-B wrote: noted around 6:30 a.m., resident had a vaso syncopal episode while on toilet. Blood pressure (BP) was 90/60 all other vitals within normal limits (WNL). He was trying to have a bowel movement (BM) and bear down. Now at 5:45 p.m., resident is still in toilet and unable to have a BM. ULP states he is in a lot of pain, they have tried everything prune juice, milk of magnesia, suppositories and pushing fluids, nothing has helped. Writer called an updated hospice RN. Staff also stated he [R15] has loose stool coming out around hard stool, indicated impaction.<br>- on October 8, 2023, at 7:52 p.m., an LPN wrote: RN from hospice inserted an enema, now waiting for results.<br><br>R1's record lacked any further progress notes after October 8, 2023, and lacked a reassessment completed by CNS-B for the change in conditions noted above.<br><br>On October 16, 2023, at 2:59 p.m., CNS-B stated a fall and change of condition assessment had not been completed for R15 or R1. CNS-B stated she was unaware individualized information could be entered into an assessment as changes in condition occurred and thought a progress note was all that was needed when anything different came up.<br><br>The licensee's Resident Change in Condition or | {01620} | | |

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| {01620} | Continued From page 13<br>Need policy dated September 1, 2021, indicated when changes in condition or need are identified, an RN would initiate a change in condition assessment.<br><br>No further information was provided. | {01620} | | |

Electronically Delivered

August 23, 2023

Licensee
Americare Lodges
20371 Wendigo Park Road Bldg 3
Grand Rapids, MN  55744

RE:  Project Number(s) SL36294015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL36294015-0<br><br>On August 7, 2023, through August 9, 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 18 active residents whom were receiving services under the Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 115 SS=F | 144G.10 Subd. 2 Licensure categories<br><br>(a) The categories in this subdivision are established for assisted living facility licensure. | 0 115 | | |

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| 0 115 | Continued From page 1<br>(1) The assisted living facility category is for assisted living facilities that only provide assisted living services.<br>(2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit.<br>(b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an assisted living with dementia care license was in place to meet compliance as the three campus buildings were secured and residents were not able to leave the buildings without assistance. This had the potential to affect all residents.<br><br>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).<br><br>Findings included:<br><br>Review of the Application for Assisted Living License dated May 4, 2022, indicated the licensee agreed to an assisted living facility license category.<br><br>During the visit on August 7, 2023, through | 0 115 | | |

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| 0 115 | Continued From page 2<br><br>August 9, 2023, the surveyor noted the front and back exit doors of all three resident buildings were secured with key code access and sliding doors were secured with motion sensor alarms.<br><br>A review of the resident roster indicated the licensee identified seven of the eight residents residing in building three (3) with a diagnosis of dementia; three of three residents in building one (1) as mental health diagnoses; and seven of seven residents in building four (4) as assisted living/independent.<br><br>On August 7, 2023, at 10:35 a.m., the surveyor toured the campus with clinical nurse supervisor (CNS)-B, which included three buildings housing residents and one additional building providing administration support offices. CNS-B stated the campus buildings were setup to house residents with similar diagnoses. Building 1 was mental health, building 3 was dementia and building 4 was assisted living and residents that were able to be more independent. The surveyor observed all three houses had keypads at the entrance/exits and a key code was required to be entered for the exit doors to be opened. Additionally, the surveyor observed an alarm attached to the sliding door on the back of building 3's dining room that alerted loudly if the door was opened. CNS-B stated, "only staff have the key codes".<br><br>On August 8, 2023, at 9:57 a.m., the surveyor interviewed CNS-B and licensed practical nurse (LPN)-E. LPN-E stated there were a few residents in house 3 that would be able to go outside with frequent checks by staff, but the others had to remain indoors within a secure unit unless they (residents) left with staff or family. LPN-E and CNS-B stated there were no residents | 0 115 | | |

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| 0 115 | Continued From page 3<br><br>on the campus with the access code to exit any of the buildings. The surveyor asked CNS-B if she understood having the buildings locked without allowing the residents the code to exit meant the entire facility campus was operating as a secured facility. CNS-B and LPN-E stated "yes", CNS-B stated, "I can understand how it appears that way." LPN-E stated the licensee had admitted five residents in March 2023, to building 3, from a secured memory care facility nearby that had closed.<br><br>Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 115 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was | 0 480 | | |

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| 0 480 | Continued From page 4<br><br>prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 8, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 770 SS=F | 144G.45 Subdivision 1 Minimum site Requirements<br><br>The following are required for all assisted living facilities:<br>(1) public utilities must be available, and working or inspected and approved water and septic systems must be in place;<br>(2) the location must be publicly accessible to fire department services and emergency medical services;<br>(3) the location's topography must provide sufficient natural drainage and is not subject to flooding;<br>(4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and | 0 770 | | |

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| 0 770 | Continued From page 5<br><br>visitors' parking at the site; and<br>(5) the location must include space for outdoor activities for residents.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to test the well water within the last year. This had the potential to directly affect all residents and staff.<br><br>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).<br><br>The findings:<br><br>A record review of available documentation and interview were conducted on August 8, 2023, at approximately 3:00 p.m. of documents provided by licensed assisted living director in residence (LALDIR)-A and scheduling coordinator (S)-I. A well water test report dated 2-1-2022 was provided for building #3 and #4. There was no water well test documentation available for review for building #1. Domestic well water is required to be tested annually.<br><br>This deficiency was verified by LALDIR-A and S-I during the interview.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 770 | | |

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| 0 780 | Continued From page 6 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide working and interconnected smoke alarms in the resident rooms and corridors throughout the facility. This deficient condition had the ability to affect all staff and residents.<br><br>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 | 0 780 | | |

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| 0 780 | Continued From page 7<br><br>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).<br><br>Findings include:<br><br>On a facility tour on August 8, 2023, at approximately 1:45 p.m. with scheduling coordinator (S)-l it was observed that smoke detectors were installed throughout the facility, but one was missing from its base in the corridor in building #3.<br><br>It was also observed smoke alarms in building #3 had a manufacture date of 2007. Smoke alarms are required to be maintained according to manufactures installation instructions for length of service.<br><br>It was observed that battery powered smoke alarms had been installed to replace the electrically hardwired alarms installed at the time of construction in building #3. Smoke alarms are required to receive power from the building electrical system as designed and installed at the time of construction.<br><br>The smoke alarms were not operational or interconnected in the corridor and resident room 1 of building #4. Smoke alarms are required to be maintained according to manufactures installation instructions and interconnected so activation of one alarm activates all alarms throughout the facility.<br><br>This deficient finding was visually verified by S-l at the time of discovery. | 0 780 | | |

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| | 36294 | A. BUILDING: _____ B. WING _____ | 08/09/2023 |

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| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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| 0 780 | Continued From page 8<br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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 residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's 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.<br><br>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).<br><br>Findings include:<br><br>On a facility tour on August 8, 2023, at approximately 2:30 p.m. with scheduling coordinator (S)-I it was observed that emergency/ exit lights did not activate and light with test | 0 800 | | |

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| 0 800 | Continued From page 9<br>button in buildings #3 and #4.<br><br>It was observed and stated by facility staff the fire sprinkler system in building #1 was not operational. Fire sprinkler systems are required to be maintained in working condition as designed and installed at the time of construction approval.<br><br>It was also observed that the mechanical room off the dining room in building #3 contained storage in amounts which did not allow access to mechanical equipment. Mechanical equipment clearances shall be maintained according to manufactures installation and operation instructions.<br><br>It was observed that refrigerators and freezers were plugged into one power tap in the room containing the sprinkler system riser in building #3 and #4. Refrigerators and freezers are required to be plugged directly into electrical outlets.<br><br>A water leak was observed causing the floor to be wet near the water heater in building #4. Water heaters are required to be maintained free of leaks and according to manufactures installation and operation instructions.<br><br>It was observed that siding was loose and damaged on the front of building #4. Exterior finish material is required to be maintained as designed and installed at the time of construction.<br><br>It was observed the exterior building numbers identifying building #3 and #4 had fallen off the front of the facilities. Building identification numbers are required to be maintained for use of building identification for emergency services in the event of an emergency. | 0 800 | | |

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| 0 800 | Continued From page 10<br><br>These deficient conditions were visually verified by S-I accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of | 0 810 | | |

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| 0 810 | Continued From page 11<br><br>the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>A record review of available documentation and interview were conducted on August 8, 2023, at approximately 12:30 p.m. of documents provided by licensed assisted living director in residence (LALDIR)-A and scheduling coordinator (S)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Findings include:<br><br>Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of | 0 810 | | |

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| 0 810 | Continued From page 12<br>direction for evacuation.<br><br>Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for these facilities and buildings located within the plan.<br><br>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan.<br><br>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.<br><br>Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan.<br><br>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. LALDIR-A indicated the resident training is provided along with employee training but was not documented.<br><br>Record review of the available documentation did | 0 810 | | |

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| 0 810 | Continued From page 13<br><br>not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required.<br><br>All deficiencies were verified by LALDIR-A and S-I during the interview.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 820 SS=F | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff.<br><br>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 | 0 820 | | |

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| 0 820 | Continued From page 14<br><br>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).<br><br>Findings include:<br><br>On a facility tour on August 8, 2023, at approximately 2:00 p.m. with scheduling coordinator (S)-I, it was observed the marked exterior exit doors were provided with locks that required a key code to unlock from the interior in order to exit the facility in buildings #1, #3 and #4. During the tour S-I indicated the marked exterior exit door locks were not fail safe so that activation of a fire alarm system, fire sprinkler system or loss of electrical power releases the door lock for the purpose of exiting in the event of an emergency. Controlled egress doors are required to fail safe (unlock and release to open) upon activation of the fire sprinkler system, fire alarm system or loss of electrical power to the door.<br><br>It was also observed an exterior exit gate from the secure outdoor deck area of building #3 was provided with a bicycle lock that required a code for egress. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors and fail safe. All clinical staff are required to carry a key or keypad combination to release the latch of the secured gate for egress.<br><br>This deficient condition was verified by S-I accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 820 | | |

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| 01620 | Continued From page 15 | 01620 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment by a registered nurse (RN) for one of three residents (R9) with a change of condition.<br><br>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 | 01620 | | |

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| 01620 | Continued From page 16<br><br>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).<br><br>The findings include:<br><br>R9 was admitted to the facility on March 27, 2023.<br><br>R9's diagnoses included dementia with behavioral disturbance, mood disorder and degenerative arthritis.<br><br>R9's unsigned service plan (original sent to family for signature) dated August 8, 2023, indicated R9 received services to include bathing, repositioning, dressing, grooming, incontinence cares, escort/mobility assistance, transfer assist, meal assistance, medication administration, behavior management, safety checks, housekeeping, and laundry.<br><br>R9's 90-day nursing assessment dated July 7, 2023, indicated R9 had a severe cognitive impairment, required assistance with dressing, grooming, bathing, incontinent cares, toileting, repositioning, ambulation, medication administration, experiences inability to relax, excessive worry, poor concentration, and mood swings.<br><br>R9's record indicated July 23, 2023, and July 29, 2023, staff documented a change in condition into R9's progress notes as follows:<br><br>- July 23, 2023, at 2:47 p.m., a licensed practical nurse (LPN) wrote: "resident noted to have bright | 01620 | | |

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| 01620 | Continued From page 17<br><br>red blood with brief change per unlicensed personnel (ULP). Today while cleaning her rectal area, she had a scant amount of bright red blood. She has small open areas around her rectum most likely caused from having loose stool. Applied barrier cream to rectum and will monitor."<br><br>- July 29, 2023, at 5:27 p.m., a ULP wrote: "about 4 o'clock me and coworker laid resident down to change brief and resident kept saying "ouch". Staff changed brief and resident had bloody mucus in bowel movement (BM). Staff cleaned resident up and applied barrier cream. Will reposition resident from side to side to be off butt throughout shift. Writer administered as needed (PRN) hydro. On call nurse notified."<br><br>R9's record lacked a progress note or a reassessment entered by an RN addressing the change in condition noted above.<br><br>On August 8, 2023, at 4:50 p.m., clinical nurse supervisor (CNS)-B stated a change of condition assessment had not been completed since R9's last assessment on July 7, 2023 and was unsure of the reason.<br><br>The licensee's Resident Change in Condition or Need policy dated September 1, 2021, indicated when changes in condition or need are identified, an RN would initiate a change in condition assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01620 | | |

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| 01880 | Continued From page 18 | 01880 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure medications were securely stored. This had potential to affect all residents, visitors, and facility staff.<br><br>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).<br><br>The findings include:<br><br>On August 8, 2023, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D open the medication cart, remove medication bubble packs (foil backed medication organizer), verify R13's medications with the electronic medication record (EMAR), pop the medication pills out of the bubble packs and into a small medication cup and exit the room. The following medications remained unsecured on top of the medication cart, in a room off from the main living area, with the door open and accessible to other residents, staff and/or visitors in the facility.<br>- aspirin (blood thinner) 81 milligram (mg) one | 01880 | | |

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| 01880 | Continued From page 19<br><br>time daily by mouth (PO);<br>- furosemide (diuretic) 20 mg take one tablet daily PO;<br>- lisinopril (treats high blood pressure) 40 mg take one tablet daily PO;<br>- metoprolol (heart rate stabilizer) 100 mg give twice daily by PO; and<br>- verapamil (treats high blood pressure) 180 mg take one tablet daily PO.<br><br>On August 8, 2023, at 8:50 a.m., the surveyor interviewed ULP-D and asked if he had been taught that medications could be unsecured when he left the medication cart and left the door open. ULP-D stated, "no, I shouldn't have done that."<br><br>On August 8, 2023, at 9:45 a.m., the surveyor interviewed clinical nurse supervisor (CNS)-B and asked what staff were taught for securing medications. CNS-B stated, "the right way to do it is med room doors are closed and locked at all times when staff are not present".<br><br>The licensee's Medication Storage policy dated September 1, 2021, indicated medications would be kept securely locked and stored per manufacturer's directions and only authorized staff would have access to stored medications.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 02370 SS=F | 144G.91 Subd. 9 Right to come and go freely<br><br>Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and | 02370 | | |

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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 |
|---|---|---|---|---|
| 02370 | Continued From page 20<br>consistent with a resident's service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure 11 of 11 residents (R1, R2, R3, R4, R5, R7, R8, R9, R10, R11, R12) had the right to enter and leave the facility as they chose.<br><br>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).<br><br>The findings include:<br><br>The licensee held an Assisted Living license for a resident capacity of 28.<br><br>Building one (1), building three (3), and building four (4) were secured houses located on the campus which required a code for the keypad to exit the houses.<br><br>Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area.<br><br>During the entrance conference on August 7, | 02370 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36294 | A. BUILDING: _____ B. WING _____ | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02370 | Continued From page 21<br><br>2023, at 10:00 a.m., clinical nurse supervisor (CNS)- B stated all residents received the Minnesota Assisted Living Bill of Rights upon admission. CNS-B described each building located on the campus as "building 1 is more mental health, building 3 is our dementia building, and building 4 is more assisted living/independent."<br><br>R1<br>R1's Resident Profile indicated R1 was admitted December 8, 2022. R1's diagnoses included Alzheimer's dementia, gastric ulcer, diabetes mellitus type II, sleep apnea, chronic kidney disease, seizures, and chronic obstructive pulmonary disease (COPD).<br><br>R1's service plan dated December 9, 2022, indicated R1 received services to include activity assistance, bathing, dressing, grooming, toileting, incontinence cares, escort/mobility assistance, medication administration, oxygen management, behavior management, safety checks, housekeeping, and laundry.<br><br>R1's comprehensive assessment dated June 22, 2023, indicated R1 was not at risk for wandering or elopement.<br><br>R1 did not have the code to leave the secured building 3 freely.<br><br>R2<br>R2's Resident Profile indicated R2 was admitted March 17, 2023. R2's diagnoses included dementia, depression, cataracts, Parkinson's disease, hallucinations, and chronic back pain.<br><br>R2's service plan dated March 17, 2023, indicated R2 received services to include activity | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 22<br><br>assistance, bathing, dressing, grooming, incontinence cares, escort/mobility assistance, meal assistance, medication administration, behavior management, safety checks, housekeeping, and laundry.<br><br>R2's comprehensive assessment dated July 10, 2023, indicated R2 required assistance for locomotion due to physical impairment and was not at risk for wandering or elopement.<br><br>R2 did not have the code to leave the secured building 3 freely.<br><br>R3<br>R3's Resident Profile indicated R3 was admitted March 9, 2023. R3's diagnoses included Alzheimer's dementia, myocardial infraction (heart attack), diabetes type II, hypertension, and psychosexual dysfunction.<br><br>R3's service plan dated March 17, 2023, indicated R2 received services to include activity assistance, bathing, dressing, grooming, incontinence cares, escort/mobility assistance, meal assistance, medication administration, behavior management, safety checks, housekeeping, and laundry.<br><br>R3's comprehensive assessment dated June 22, 2023, indicated R3 wandered throughout the facility, however, was not at risk for elopement.<br><br>R3 did not have the code to leave the secured building 4 freely.<br><br>R4<br>R4's service plan dated August 2, 2023, indicated R4 was admitted April 10, 2023. R4's diagnoses included major depressive disorder, severe | 02370 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36294 | A. BUILDING: _____ B. WING _____ | 08/09/2023 |

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| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02370 | Continued From page 23<br>obesity, and schizophrenia.<br><br>R4's Service Plan indicated R4 received services to include activity assistance, bathing, medication administration, behavior management, vital sign monitoring, well-being checks, laundry, and housekeeping.<br><br>R4's comprehensive assessment dated July 18, 2023, indicated R4 was not at risk for wandering or elopement.<br><br>R4 did not have the code to leave the secured building 1 freely.<br><br>R5<br>R5's service plan dated August 1, 2023, indicated R5 was admitted April 10, 2023. R5's diagnoses included bipolar disorder, attention deficit hyperactivity disorder (ADHD), and Asperger syndrome.<br><br>R5's Service Plan indicated R5 received services to include bathing reminders, medication administration, behavior management, vital sign monitoring, well-being checks, laundry, and housekeeping.<br><br>R5's comprehensive assessment dated July 18, 2023, indicated R5 was not at risk for wandering or elopement.<br><br>R5 did not have the code to leave the secured building 1 freely.<br><br>R7<br>R7's Resident Profile indicated R7 was admitted March 21, 2023. R7's diagnoses included a history of mental disorder, anxiety, major depressive disorder, seizure disorder, diabetes | 02370 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36294 | A. BUILDING: _____ B. WING _____ | 08/09/2023 |

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| AMERICARE LODGES | 20371 WENDIGO PARK ROAD BLDG 3 GRAND RAPIDS, MN 55744 |

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|---|---|---|---|---|
| 02370 | Continued From page 24<br>mellitus, and memory loss.<br><br>R7's service plan dated August 1, 2023, indicated R7 received services to include activity assistance, bathing assist, behavior management, dressing, grooming, incontinence cares, toileting assist, transfer assist, mobility assistance, compression stockings (TEDs), medication management, housekeeping, and laundry.<br><br>R7's Individual Abuse Prevention Plan (IAPP) dated July 3, 2023, indicated R7 was not at risk for wandering or elopement.<br><br>R7 did not have the code to leave the secured building 3 freely.<br><br>R8<br>R8's Resident Profile indicated R8 was admitted March 22, 2023. R8's diagnoses included dementia, cerebral infarction, diabetes mellitus type II, and history of falls.<br><br>R8's service plan dated March 22, 2023, indicated R8 received services to include activity assistance, bathing assist, behavior management, dressing, grooming, incontinence cares, toileting assist, medication management, vital sign monitoring, safety checks, housekeeping, and laundry.<br><br>R8's IAPP dated July 7, 2023, indicated R8 wandered inside the facility, however, was not at risk for elopement.<br><br>R8 did not have the code to leave the secured building 3 freely.<br><br>R9 | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 25<br><br>R9's Resident Profile indicated R9 was admitted March 27, 2023. R9's diagnoses included dementia, seizures, mood disorder, low back pain, and hearing loss.<br><br>R9's unsigned service plan (original sent to family for signature) dated August 8, 2023, indicated R9 received services to include bathing, repositioning, dressing, grooming, incontinence cares, escort/mobility assistance, transfer assist, meal assistance, medication administration, behavior management, safety checks, housekeeping, and laundry.<br><br>R9's comprehensive assessment dated July 7, 2023, indicated R9 was not at risk for elopement.<br><br>R9 did not have the code to leave the secured building 3 freely.<br><br>R10<br>R10's Resident Profile indicated R10 was admitted March 23, 2023. R10's diagnoses included Alzheimer's dementia, diabetes mellitus type II, Lewy body dementia, bradycardia, and hypertension.<br><br>R10's service plan dated July 26, 2023, indicated R10 received services to include bathing, dressing, grooming, incontinence cares, escort/mobility assistance, repositioning, meal assistance, drinking assistance, toileting, medication administration, behavior management, safety checks, vital sign monitoring, housekeeping, and laundry.<br><br>R10's comprehensive assessment dated July 7, 2023, indicated R10 was not at risk for wandering or elopement. | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 26<br><br>R10 did not have the code to leave the secured building 3 freely.<br><br>R11<br>R11's Resident Profile indicated R11 was admitted January 18, 2021. R11's diagnoses included depressive disorder.<br><br>R11's service plan dated July 20, 2023, indicated R11 received services to include bathing reminders, dressing, grooming, meal assistance, medication administration, behavior management, vital sign monitoring, safety checks, laundry, and housekeeping.<br><br>R11's comprehensive assessment dated July 18, 2023, indicated R11 was not at risk for wandering or elopement.<br><br>R11 did not have the code to leave the secured building 1 freely.<br><br>R12<br>R12's Resident Profile indicated R12 was admitted July 12, 2022. R12's diagnoses included diabetes type II, peripheral arterial disease, bipolar disorder, schizoaffective disorder, anxiety, and depression.<br><br>R12's service plan dated August 1, 2023, indicated R12 received services to include activities, bathing, dressing, compression stockings (TEDs), grooming reminders, toileting reminders, medication administration, housekeeping, and laundry.<br><br>R12's comprehensive assessment dated July 20, 2023, indicated R12 was at risk for elopement if R12 became agitated. | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 27<br><br>R12 did not have the code to leave the secured building 4 freely.<br><br>On August 7, 2023, at 10:35 a.m., the surveyor toured the campus with CNS-B, which included three buildings housing residents and one additional building providing administration support offices. CNS-B stated the campus buildings were setup to house residents with similar diagnoses. Building 1 was mental health, building 3 was dementia and building 4 was assisted living and residents that were able to be more independent. The surveyor observed all three houses had keypads at the entrance/exits and a key code was required to be entered for the exit doors to be opened. Additionally, the surveyor observed an alarm attached to the sliding door on the back of building 3's dining room that alerted loudly if the door was opened without deactivating the alarm. CNS-B stated, "only staff have the key codes."<br><br>On August 7, 2023, at 10:43 a.m., the surveyor went back to building 1 and interviewed unlicensed personnel (ULP)-H and asked if residents residing in building 1 were given the key code to freely exit the building. ULP-H stated, "no, only staff have the code. They [residents] come to us when they want to go out and we enter the code. Technically we are not a secure facility." ULP-H entered the key code for the surveyor to exit the building.<br><br>On August 7, 2023, at 11:32 a.m., the surveyor interviewed ULP-D and asked if residents residing in building 4 were given the key code to freely exit the building. ULP-D stated, "no, only staff have the code. We let them outside when they ask." ULP-D entered the key code for the surveyor to exit the building. | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 28<br><br>On August 7, 2023, at 2:20 p.m., the surveyor interviewed ULP-F. The surveyor asked ULP-F if she knew why the exit doors on building 3 were secured with a key code locking system. ULP-F stated the doors were secured due to the building's residents being elopement risks but were able to leave the building with family or staff.<br><br>On August 8, 2023, at 7:53 a.m., the surveyor observed licensed practical nurse (LPN)-E replace batteries in the alarm system attached to the sliding door on the back of the dining room in building 3. LPN-E tested the alarm and the alarm alerted loudly when LPN-E attempted to open the door. LPN-E exited building 3 by entering the key code into the keypad.<br><br>On August 8, 2023, at 8:09 a.m., the surveyor interviewed ULP-G and asked if residents or their families have the key code to exit building 3 freely. ULP-G stated, " none of the residents or families have the key code, only staff have it. They come to us, and we let them out." The surveyor asked if any of the residents in building 3 were exit seeking or exhibited exit seeking behaviors and ULP-G stated, "no." ULP-G entered the key code for the surveyor to exit the building.<br><br>On August 8, 2023, at 8:40 a.m., the surveyor observed R12 sitting outside building 4 on a chair. The surveyor asked if staff had opened the door for him so he could sit outside. The resident stated, "yes." The surveyor interviewed ULP-D and asked if ULP-D had entered a code for the resident to go outside and ULP-D stated, "yes, I like to let him go out when the sun pokes out." Additionally, ULP-D stated at times the keypad is inactivated during the day, however, ULP-D | 02370 | | |

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|---|---|---|---|---|
| 02370 | Continued From page 29<br><br>states, "it's always active at night, I don't want them going out in the dark without me knowing." ULP-D entered the key code for the surveyor to exit the building.<br><br>On August 8, 2023, at 9:57 a.m., the surveyor interviewed CNS-B and LPN-E. LPN-E stated there were a few residents in house 3 that would be able to go outside with frequent checks by staff, but the others had to remain indoors within a secure unit unless they (residents) left with staff or family. The surveyor asked for clarification of what LPN-E considered frequent and LPN-E stated, "staff visualize the resident every 15 minutes." LPN-E and CNS-B stated there were no residents on the campus with the access code to exit any of the buildings. The surveyor asked CNS-B if she understood having the buildings locked without allowing the residents the code to exit meant the entire facility campus was operating as a secured facility. CNS-B and LPN-E stated "yes", CNS-B stated, "I can understand how it appears that way." LPN-E stated, "building 1 residents were in charge of themselves and can come and go as they choose. Some of building 4 independents have guardians and need guardian approval to leave the grounds, as long as they stay on the grounds, they can leave the building." The surveyor asked if any of those residents referred to by LPN-E in building 1 or building 4 were provided the key code for the exit doors, LPN-E stated, "no."<br><br>The licensee's Protecting Resident Rights policy dated September 1, 2021, indicated it was the policy of the licensee to protect the rights of their residents and [licensee] would not request or require that any resident waive any rights provided at any time for any reason, including as a condition of admission. Prior to, or at the time | 02370 | | |

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| 02370 | Continued From page 30<br><br>of admission, all residents would be provided a copy of the Minnesota Assisted Living Bill of Rights.<br><br>The Minnesota Bill of Rights for Assisted Living Residents dated August 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02370 | | |

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/08/23*
Time: 12:24:13
Report: 7939231129

# Food and Beverage Establishment Inspection Report



**Location:**

Americare Lodges - BUILDING 1
20371 Wendigo Park Road Bldg 3
Grand Rapids, MN55744
Itasca County, 31

**Establishment Info:**

ID #: 0038838
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2183010536
ID #:

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

The following orders were issued during this inspection.

**4-700 Sanitizing Equipment and Utensils**

***4-703.11B*** ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

ESTABLISHMENT COULD NOT PROVIDE PROOF WARE WASH MACHINE IS MEETING THIS ORDER.

*Comply By: 08/08/23*

**Surface and Equipment Sanitizers**

Hot Water: = at Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: Yes

**Food and Equipment Temperatures**

Process/Item: PASTA
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

DISCUSSION
PLEASE REVIEW THE ENCLOSED FACT SHEET CONCERNING PROPER COOLING OF COOKED ITEMS

ESTABLISHMENT COULD NOT PRODUCE PROOF THAT THE MACHINE IS REACHING

# Food and Beverage Establishment Inspection Report



PROPER SANITIZING TEMPERATURE. MACHINES ARE NOT ANSI APPROVED. PLEASE PROVIDE PROOF THE MACHINES MEET THE 160F PLATE TEMPERATURE REQUIRED. TEST STRIPS LEFT WITH DESEREE.

LINKS TO EXAMPLES OF TEMPERATURE TESTING WILL BE INCLUDED IN A SEPARATE EMAIL TO KAITLIN HANSON

**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 7939231129 of 08/08/23.

Certified Food Protection Manager:_____

Certification Number: FM110872 Expires: 03/25/25

Signed:_____

DESIREE HECKMAN
CFPM

Signed:_____

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/08/23*
Time: 12:41:51
Report: 7939231130

# Food and Beverage Establishment Inspection Report



**Location:**

Americare Lodges - BUILDING 3
20371 Wendigo Park Road Bldg 3
Grand Rapids, MN55744
Itasca County, 31

**Establishment Info:**

ID #: 0038838
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2183010536
ID #:

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

The following orders were issued during this inspection.

**4-700 Sanitizing Equipment and Utensils**

***4-703.11B*** ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

ESTABLISHMENT COULD NOT PRODUCE PROOF THE THE WARE WASH MACHINE MEETS THIS ORDER. SEE GENERAL COMMENT SECTION.

*Comply By: 08/08/23*

**Surface and Equipment Sanitizers**

Hot Water: = at Degrees Fahrenheit
Location: WARW WASH MACHINE
Violation Issued: Yes

**Food and Equipment Temperatures**

Process/Item: MAYO
Temperature: 39 Degrees Fahrenheit - Location: BOTTOM FRIDGE
Violation Issued: No

Process/Item: CHICKEN BASE
Temperature: 39 Degrees Fahrenheit - Location: TOP FRIDGE
Violation Issued: No

Process/Item: APPLESAUCE
Temperature: 36 Degrees Fahrenheit - Location: BACK ROOM FRIDGE
Violation Issued: No

Type: Full
Date: *08/08/23*
Time: 12:41:51
Report: 7939231130
Americare Lodges - BUILDING 3

# Food and Beverage Establishment Inspection Report

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

DISCUSSION - BUILDING 3
PLEASE REVIEW THE ENCLOSED FACT SHEET CONCERNING PROPER COOLING OF COOKED ITEMS

ESTABLISHMENT COULD NOT PRODUCE PROOF THAT THE MACHINE IS REACHING PROPER SANITIZING TEMPERATURE. MACHINES ARE NOT ANSI APPROVED. PLEASE PROVIDE PROOF THE MACHINES MEET THE 160F PLATE TEMPERATURE REQUIRED. TEST STRIPS LEFT WITH DESEREE.

LINKS TO EXAMPLES OF TEMPERATURE TESTING WILL BE INCLUDED IN A SEPARATE EMAIL TO KAITLIN HANSON

**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 7939231130 of 08/08/23.

Certified Food Protection Manager:_____

Certification Number: FM110872 Expires: / /

Signed:_____
DESIREE HECKMAN
CFPM

Signed:_____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/08/23*
Time: 12:56:01
Report: 7939231131

# Food and Beverage Establishment Inspection Report



**Location:**

Americare Lodges - BUILDING 4
20371 Wendigo Park Road Bldg 3
Grand Rapids, MN55744
Itasca County, 31

**Establishment Info:**

ID #: 0038838
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2183010536
ID #:

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

The following orders were issued during this inspection.

**4-700 Sanitizing Equipment and Utensils**

***4-703.11B*** ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

ESTABLISHMENT COULD NOT PRODUCE PROOF THE WARE WASH MACHINE WAS MEETING THIS ORDER. SEE GENERAL COMMENT SECTION

*Comply By: 08/08/23*

**Surface and Equipment Sanitizers**

Hot Water: = at Degrees Fahrenheit
Location: WARE WASH MACIHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: JELLY
Temperature: 36 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: CHICKEN
Temperature: 139 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Type: Full
Date: *08/08/23*
Time: 12:56:01
Report: 7939231131
Americare Lodges - BUILDING 4

# Food and Beverage Establishment Inspection Report

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

DISCUSSION - BUILDING 4
PLEASE REVIEW THE ENCLOSED FACT SHEET CONCERNING PROPER COOLING OF COOKED ITEMS

ESTABLISHMENT COULD NOT PRODUCE PROOF THAT THE MACHINE IS REACHING PROPER SANITIZING TEMPERATURE. MACHINES ARE NOT ANSI APPROVED. PLEASE PROVIDE PROOF THE MACHINES MEET THE 160F PLATE TEMPERATURE REQUIRED. TEST STRIPS LEFT WITH DESEREE.

LINKS TO EXAMPLES OF TEMPERATURE TESTING WILL BE INCLUDED IN A SEPARATE EMAIL TO KAITLIN HANSON

**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 7939231131 of 08/08/23.

Certified Food Protection Manager:_____

Certification Number: FM110872 Expires: / /

Signed:_____
DESIREE HECKMAN
CFPM

Signed:_____
RYAN TRENBERTH
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