Electronically Delivered

May 30, 2025

Licensee
Ingleside
2811 Roland Avenue
Fairmont, MN 56031

RE: Project Number(s) SL30245016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30245016-0 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 49 residents; 48 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and 911 emergency phone number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 640		

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0 640	Continued From page 4 The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the facility tour on April 21, 2025, at 10:30 a.m. the surveyor observed the common areas within the facility and noted there was no posting of the 911 emergency number as required. On April 21, 2025, at 10:45 a.m., housing director (HD)-C stated the 911 emergency number was not posted in common areas or near facility telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790		

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0 790	Continued From page 5 failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on April 21, 2025, from 11:47 a.m. through 1:08 p.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and housing director (HD)-C, the surveyor observed the following: The portable fire extinguishers located in the basement mechanical room, and the mechanical room by door 7 had a tag indicating the last annual service was performed in January 2024 and expired in January 2025. Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. The portable fire extinguishers throughout the facility lacked records to show the required monthly visual inspections were performed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. The portable fire extinguisher cabinets located in	0 790		

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0 790	Continued From page 6 the dinging room, by door 4, by the laundry room, and by the garage were locked and required a key to open. Fire extinguisher cabinets must be unlocked so the extinguishers are readily available for use during a fire. LALD-A, DM-D and HD-C verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 7 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 21, 2025, at 1:23 p.m., licensed assisted living director (LALD)-A and housing director (HD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensees FSEP titled, Emergency Response Policy & Procedure: Fire Policy and Procedure, dated 11/10/2021, lacked the following required content.	0 810		

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0 810	Continued From page 8 The FSEP included standard resident evacuation procedures but lacked specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. During an interview on April 21, 2025, at 2:03 p.m., LALD-A stated that the resident needs were in resident care plans that are stored electronically. LALD-A stated that all staff have access to the care plans on computers or other devices. The FSEP lacked instructions for staff on how to access the care plan information. LALD-A and HD-C stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 9 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R3). 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	01060		

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01060	Continued From page 10 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 began receiving assisted living services on August 5, 2023, with diagnoses of dementia and Alzheimer's disease. R3's service plan dated March 11, 2025, indicated R3 received assistance with bathing, dressing, toileting, and medication administration. R3's progress notes dated April 7, 2025, at 3:58 p.m., indicated R3 had been transferred to the emergency department on April 5, 2025, following a fall in her bedroom and an unresponsive episode while on the toilet with staff. R3's progress notes dated April 8, 2025, at 3:08 p.m. identified R3 had discharged from hospital and returned to the facility (three days later). R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 11 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On April 22, 2025, at 1:49 p.m., clinical nurse supervisor (CNS)-B stated no written notice was provided to R3 or any resident that had been emergently relocated unless they were gone more than four days. CNS-B stated she had misunderstood the regulation and thought the notice only needed to be given out if the resident was relocated greater than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370		

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01370	Continued From page 12 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-E, and ULP-H.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01370		

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	30245	A. BUILDING: _____ B. WING _____	04/23/2025

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01370	Continued From page 13 ULP-E ULP-E was hired on May 29, 2024, to provide direct care services to residents at the assisted living. ULP-E's record lacked evidence the following training had been completed prior to providing direct cares: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility. ULP-H ULP-H was hired on January 19, 2024, to provide direct care services to residents at the assisted living. ULP-H's record lacked evidence the following training had been completed prior to providing direct cares: - understanding appropriate boundaries between staff and residents and the resident's family. On April 23, 2025, at 2:50 p.m., licensed assisted living director (LALD)-A stated evidence of training on the above topics were missing from ULP-E and ULP-H's employee file. The licensee's Assisted Living Orientation- ULP Staff policy dated as revised November 29, 2023, identified in addition to training all staff receive, ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test on the above missing topics. No further information was provided.	01370		

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01370	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-E, and ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01380		

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01380	Continued From page 15 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had an employment start date of May 29, 2024. ULP-E's employee record lacked documentation of training/competency for the following topic: - reading and recording temperature, pulse, and respirations of the resident. ULP-H had an employment start date of January 19, 2024. ULP-H's employee record lacked documentation of training for the following topics: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On April 23, 2025, at 2:50 p.m., licensed assisted living director (LALD)-A stated evidence of training on the above topics were missing from ULP-E and ULP-H's employee file. The licensee's Assisted Living Orientation- ULP Staff policy dated as revised November 29, 2023, identified in addition to training all staff receive, ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test for: q. Basic knowledge of body functioning, changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel.	01380		

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01380	Continued From page 16 r. Recognizing physical, emotional, cognitive and developmental needs of the resident. In addition, the policy noted ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration for: k. Reading and recording temperature, pulse and respirations of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the	01540		

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01540	Continued From page 17 licensee failed to ensure one of two employees (unlicensed personnel (ULP-E) completed the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E had a hire date of May 29, 2024, to provide direct care services under the licensee's assisted living with dementia care license. ULP-E's employee record contained evidence of 2.75 hours of training on dementia care topics, instead of the required eight hours. On April 23, 2025, at 2:20 p.m., licensed assisted living director (LALD)-A stated ULP-E was a full-time employee and had worked more than 80 hours since her start date. LALD-A stated ULP-E lacked the required eight hours of dementia training within 80 working hours as required. The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy dated as reviewed November 29, 2023, noted direct-care employees would: 1. complete a minimum of eight hours of initial training on dementia care topics; and 2. Initial training will be completed within 80 working hours of the employment start date.	01540		

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01540	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R2).	01640		

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01640	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 22, 2025, at 8:37 a.m., and on April 23, 2025, at 8:34 a.m. the surveyor observed R2 feeding herself pureed food with encouragement from staff in the dining room. R2's diagnoses included dementia. R2's service plan dated February 21, 2025, indicated R2 received services including assistance with bathing, dressing, grooming, toileting, behaviors, thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs), and medication administration. The service plan failed to identify the treatment of a pureed diet. R2's prescriber orders dated February 5, 2025, included an order for pureed diet. R2's record lacked documentation of the pureed diet. On April 23, 2025, at 3:32 p.m., clinical nurse supervisor (CNS)-B stated R2's service plan did not include the treatment of pureed diet, and it should have been revised. The licensee's Contents of Service Plans policy	01640		

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01640	Continued From page 20 dated as reviewed November 28, 2023, noted service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-B) administered medications as prescribed. 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	01760		

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01760	Continued From page 21 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included chronic rhinitis (inflammation of the nasal lining). R5's service plan dated January 24, 2025, noted services including medication administration. R5's prescriber orders dated February 4, 2025, included orders for: - fluticasone propionate (reduces inflammation) nasal spray 50 micrograms (mcg)/actuation one spray into each nostril daily. R5's medication administration record (MAR) dated April 1, 2025, through April 22, 2025, included the same order for fluticasone propionate nasal spray 50 mcg inhale one spray into each nostril daily. On April 22, 2025, at 7:23 a.m., the surveyor observed ULP-E prepare and administer medications to R5. ULP-E administered R5's oral medications, applied gloves, and administered fluticasone two sprays into each nostril. When interviewed at this time, ULP-E stated she administered two sprays of the fluticasone nasal spray because the first spray doesn't always come out. ULP-E further stated the prescriber's order was not followed. On April 22, 2025, at 2:09 p.m., clinical nurse supervisor (CNS)-B stated staff should administer medications as prescribed.	01760		

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01760	Continued From page 22 The licensee's Administration and Documentation of Routine Medications and PRN (as needed) Medications policy dated reviewed December 5, 2023, noted staff would administer medications exactly as prescribed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated reviewed December 5, 2023, noted medications always need to be administered according to the "6 Rights": e. Right dose (how many milligrams, drops, etc.) No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure time sensitive medications were dated when opened for one of five residents (R6) with insulin. 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	01890		

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01890	Continued From page 23 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 23, 2025, at 8:41 a.m., the surveyor observed the secured unit's medication cart with ULP-G. ULP-G stated insulin pens should be dated when opened and when they would expire. R6's insulin aspart (rapid-acting insulin) FlexPen and Basaglar (long-acting insulin) KwikPen did not include a date to indicate when staff opened it, or when they would expire. On April 23, 2025, at 3:34 p.m., clinical nurse supervisor (CNS)-B stated every insulin pen should be dated when opened. The insulin aspart FlexPen instructions for use revised February 2023, noted: The FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. The Basaglar KwikPen instructions for use dated revised November 2022, noted: Throw away the Pen you are using after 28 days, even if it still has insulin left in it. The licensee's Storage of Medications policy reviewed December 5, 2023, noted insulin pens need to be dated with open date and expiration. No further information was provided.	01890		

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01890	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the prescription numbers as applicable, for one of one discharged resident (R4). 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	01910		

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01910	Continued From page 25 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's discharged resident roster dated April 21, 2025, indicated R4 discharged on October 31, 2024, to another facility. R4's Order Summary Report (identified as the form used for the disposition of medications) dated October 15, 2024, included the name of medication, strength, amount remaining, signature of accepting person and signature of releasing medications person. The document did not include the prescription numbers for the prescriptions as applicable. The following medications were listed without a prescription number: - fluticasone (reduces nasal inflammation), furosemide (fluid retention), metoprolol (blood pressure), mirtazapine (antidepressant), pantoprazole (reduces acid in stomach), potassium chloride (supplement), and rosuvastatin (lowers cholesterol). On April 22, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-B stated R4's disposition of medication form lacked the prescription numbers. CNS-B stated she only documented the prescription number if she was destroying the medication, not when sending the medications with the resident/family. CNS-B further stated she was not aware of the requirement. The licensee's Disposition and Disposal of Medication policy dated reviewed December 5,	01910		

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01910	Continued From page 26 2023, noted staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. The policy did not direct to document the prescription number as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

(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
01940	Continued From page 27 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 21, 2025, at 11:08 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to their residents including modified diets and blood sugar checks. R2 On April 22, 2025, at 8:37 a.m., and on April 23, 2025, at 8:34 a.m., the surveyor observed R2 feeding herself pureed food with encouragement from staff in the dining room.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 28 R2's diagnoses included dementia. R2's service plan dated February 21, 2025, indicated R2 received services including assistance with bathing, dressing, grooming, toileting, behaviors, thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs), and medication administration. The service plan failed to identify the treatment of a pureed diet. R2's prescriber orders dated February 5, 2025, included an order for pureed diet. R2's record lacked a treatment or therapy management plan to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R5 On April 22, 2025, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-E check	01940		

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	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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01940	Continued From page 29 R5's blood sugar. R5's diagnoses included diabetes R5's service plan dated January 24, 2025, indicated R5 received assistance with blood sugar checks. R5's prescriber orders dated February 11, 2025, included blood sugar checks three times daily. R5's medication administration record (MAR) dated April 1, 2025, through April 22, 2025, included documentation of R5's blood sugar check three times daily. R5's Level of Care Form (identified as including the treatment plan) dated April 14, 2025, and MAR dated April 2025, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On April 23, 2025, at 3:32 p.m., clinical nurse supervisor (CNS)-B stated R2 and R5's record lacked a treatment management plan to include all the required content as noted above. CNS-B indicated she had not recognized R2's pureed diet as a treatment. In addition, CNS-B indicated there should be specific blood sugar parameters for staff to follow for R5. The licensee's Treatment Management Plan	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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01940	Continued From page 30 policy dated reviewed December 5, 2023, noted staff would provide treatment management services only after a face-to-face assessment had been performed by the registered nurse (RN). The RN would discuss with the resident what treatment they are receiving and the reason for the treatment. The RN would obtain orders for treatments, identify what treatments would be delegated to the ULP's, document specific instructions related to the treatment administration, and have a procedure for when to notify the nurse when a problem arises. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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01950	Continued From page 31 in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses included diabetes. R5's service plan dated January 24, 2025, indicated R5 received assistance with blood sugar checks and medication administration. R5's prescriber orders dated February 5, 2025, included the following orders: - insulin aspart 100 units/milliliter (ml), 6 units subcutaneously with breakfast and lunch, 4 units with evening meal. - Levemir 100 units/ml, 10 units subcutaneously every morning. R5's prescriber orders dated February 11, 2025, included blood sugar checks three times daily. On April 22, 2025, at 7:23 a.m., the surveyor	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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01950	Continued From page 32 observed unlicensed personnel (ULP)-E prepare and administer R5's insulin aspart (rapid-acting insulin) 6 units subcutaneously and Levemir (long-acting insulin) 10 units subcutaneously. ULP-E then removed gloves, sanitized and documented the administration. Next, ULP-E obtained R5's glucometer, put on gloves, and checked R5's blood sugar. R5's blood sugar was 118 milligrams per deciliter (mg/dl). The surveyor asked ULP-E why she administered the insulin prior to checking R5's blood sugar and what the reporting parameters were. ULP-E stated R5 did not have any listed blood sugar parameters and since he did not have a sliding scale for the insulin it didn't matter what order she completed the task in. R5's medication administration record (MAR) dated April 1, 2025, through April 22, 2025, included documentation of blood sugar checked three times per day, ranging from 56 - 279 mg/dl. R5's record lacked specific written instructions related to blood sugar monitoring/parameters or when to notify the registered nurse (RN). On April 22, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated R5's record lacked specific written instructions related to blood sugar monitoring. CNS-B stated blood sugars should be checked prior to insulin administration and parameters should be identified. The licensee's Delegation of Nursing Tasks/Treatments policy dated reviewed November 28, 2023, noted a RN would develop specific written instructions for each resident and document those instructions in the resident's medication record/MAR. No further information was provided.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 33 TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee lacked documentation of treatments for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 22, 2025, at 8:37 a.m., and on April 23, 2025, at 8:34 a.m. the surveyor observed R2	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30245	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE	2811 ROLAND AVENUE FAIRMONT, MN 56031

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01960	Continued From page 34 feeding herself pureed food with encouragement from staff in the dining room. R2's diagnoses included dementia. R2's service plan dated February 21, 2025, indicated R2 received services including assistance with bathing, dressing, grooming, toileting, behaviors, thrombo-embolic deterrent (TED) hose (compression socks used to increase circulation and reduce swelling in the legs), and medication administration. The service plan did not include the treatment of a pureed diet. R2's prescriber orders dated February 5, 2025, included an order for pureed diet. R2's record did not include documentation of the pureed diet. On April 23, 2025, at 3:32 p.m., clinical nurse supervisor (CNS)-B stated R2's record lacked documentation of the treatment provided. CNS-B indicated she had not recognized R2's pureed diet as a treatment. The licensee's Treatment Management Plan policy dated reviewed December 5, 2023, indicated treatment services would be recorded on the service plan/task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Environmental Health, FPLS
P. O. Box 64495
St. Paul, MN 55164-0495
651-201-4500

Type: Full
Date: *04/22/25*
Time: 11:00:00
Report: 1034251071

Food and Beverage Establishment Inspection Report

Location:
Ingleside
2811 Roland Avenue
Fairmont, MN56031
Martin County, 46

Establishment Info:
ID #: 0038478
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072389654
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.

3-700 Contaminated Food: discarded

3-701.11A ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

ORANGE WITH A MOLD-LIKE SUBSTANCE WAS FOUND IN DRY STORAGE. ORANGE WAS THROWN AWAY DURING INSPECTION.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

CHLORINE IN DISHWASHER IN MAIN KITCHEN TESTED AT 10 PPM. SHOULD TEST 50-100 PPM. PIC CALLED SERVICE COMPANY DURING INSPECTION AND WILL USE MEMORY CARE DISHWASHER TO ALL WASH DISHES UNTIL IT IS FIXED.

Comply By: 04/22/25

4-300 Equipment Numbers and Capacities

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

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

NEED QUATERNARY AMMONIUM (QUAT) TEST STRIPS. ALSO NEED CHLORINE TEST STRIPS THAT HAVE A COLOR COMPARATOR CHART. PIC STATED THAT BOTH WOULD BE ON THE NEXT ORDER FROM THEIR VENDOR.

Comply By: 04/24/25

Type: Full
Date: *04/22/25*
Time: 11:00:00
Report: 1034251071
Ingleside

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
A COPY OF RACHEL'S CFPM CERTIFICATE WAS POSTED. POST THE ORIGINAL CERTIFICATE.
Comply By: 05/09/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
REPAIR THE FLOOR IN THE MAIN KITCHEN BY THE ENTRANCE.
Comply By: 07/31/25

Surface and Equipment Sanitizers

Chlorine: = 10 at Degrees Fahrenheit
Location: Main Kitchen Dishwasher
Violation Issued: Yes

Chlorine: = 50 at Degrees Fahrenheit
Location: Memory Care Dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sani Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 175 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: Mashed Potatoes
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39.1 Degrees Fahrenheit - Location: Spinach Pasta
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39.4 Degrees Fahrenheit - Location: Ham
Violation Issued: No

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

Type: Full
Date: *04/22/25*
Time: 11:00:00
Report: 1034251071
Ingleside

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: Mixed Veggies
Violation Issued: No

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

Discussed the need to test dishwashers more frequently than just when the servicer comes to check them. PIC stated they would begin checking them once a day.

Discussed cooling procedures.

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 1034251071 of 04/22/25.

Certified Food Protection Manager: Rachel D Ragan

Certification Number: FM92953 Expires: 03/07/27

Inspection report reviewed with person in charge and emailed.

Signed: emailed

cworke@colonycourtmn.com

Signed: McKenna Mathews

McKenna Mathews, RS
Public Health Sanitarian 2
Mankato District Office
507-344-2729
mckenna.mathews@state.mn.us