Electronically Delivered

September 16, 2025

Licensee
Ecumen Duluth The Shores
4000 London Road
Duluth, MN  55804

RE:  Project Number(s) SL30492016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 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 . . ."

**IMPOSITION OF FINES**

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**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**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

**INFORMAL CONFERENCE**
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Ecumen Duluth The Shores. **Please contact Jessie Chenze at 218-332-5175 on or before September 19 2025, to schedule the conference call.**

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30492 | A. BUILDING: _____ B. WING _____ | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ECUMEN DULUTH THE SHORES | 4000 LONDON ROAD DULUTH, MN 55804 |

| (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 |
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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><br>SL30492016-0<br><br>On July 28, 2025, through July 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 65 residents; 50 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.<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 SUBDIVISION 1-3. | |
| 0 100 SS=F | 144G.10 Subdivision 1 License required<br><br>(a)(1) Beginning August 1, 2021, no assisted | 0 100 | | |

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| 0 100 | Continued From page 1<br>living facility may operate in Minnesota unless it is licensed under this chapter.<br>(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).<br>(b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.<br>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type.<br>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.<br>(e) Upon approving an application for an assisted | 0 100 | | |

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| 0 100 | Continued From page 2<br><br>living facility license, the commissioner may:<br>(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or<br>(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate home health care and hospice agencies. This had the potential to 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, 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 July 28, 2025, at 12:56 p.m., the surveyor entered the main entrance of the facility, which had posted three separate addresses on the door: 4000 (assisted living with dementia care), | 0 100 | | |

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| 0 100 | Continued From page 3<br><br>4002 (skilled nursing facility), and 4004 (housing). The surveyor was directed to set up in a room off the main lobby.<br><br>During the entrance conference on July 28, 2025, at 1:05 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements.<br><br>On July 28, 2025, from 1:44 p.m. through 2:07 p.m., the surveyor toured the facility with LALD/RN-A and clinical nurse supervisor (CNS)-B. The 4000 building (assisted living with dementia care facility) consisted of four levels. A home health office and hospice office were located on the lower level of the 4000 building.<br><br>The licensee's website indicated the home care office was the same 4000 address as the assisted living with dementia care facility.<br><br>On July 30, 2025, from 8:27 a.m. through 8:44 a.m., the surveyor toured the outside property of the building with LALD/RN-A and CNS-B. LALD/RN-A stated the home health and hospice offices have the same address as the assisted living with dementia care facility, however, the backside of the 4000 building had a staff entrance to use to access the lower level of the building.<br><br>On July 30, 2025, at 10:15 a.m., the Minnesota Department of Health engineer surveyor toured the facility with director of maintenance (DM)-M, LALD/RN-A, and executive director (ED)-N. During the facility tour, the engineer surveyor observed in the basement of the 40000 assisted living building there were offices for hospice and home health care. During the facility tour interview, DM-M stated this part of the basement | 0 100 | | |

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| 0 100 | Continued From page 4<br>was currently used as rental space and was not part of the assisted living facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 100 | | |
| 0 130 SS=C | 144G.12, Subd. 1 Application for Licensure<br><br>Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including:<br>(1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility;<br>(2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director;<br>(3) the name and e-mail address of the managing agent and manager, if applicable;<br>(4) the licensed resident capacity and the license category;<br>(5) the license fee in the amount specified in section 144.122;<br>(6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;<br>(7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;<br>(8) documentation that the facility has liability | 0 130 | | |

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| 0 130 | Continued From page 5<br>coverage;<br>(9) a copy of the executed lease agreement between the landlord and the licensee, if applicable;<br>(10) a copy of the management agreement, if applicable;<br>(11) a copy of the operations transfer agreement or similar agreement, if applicable;<br>(12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other;<br>(13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of:<br>(i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act;<br>(ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item | 0 130 | | |

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| 0 130 | Continued From page 6<br>or service;<br>(iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service;<br>(iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201;<br>(v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;<br>(vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period;<br>(vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority;<br>(viii) any revocation or suspension of accreditation; or<br>(ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program;<br>(14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy | 0 130 | | |

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| 0 130 | Continued From page 7<br><br>proceedings;<br>(15) the signature of the owner of the licensee, or an authorized agent of the licensee;<br>(16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority;<br>(17) statistical information required by the commissioner; and<br>(18) any other information required by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the licensee only provided assisted living services in the facility. This had the potential to 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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On July 28, 2025, at 12:56 p.m., the surveyor entered the main entrance of the facility, which had posted three separate addresses on the | 0 130 | | |

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| 0 130 | Continued From page 8<br><br>door: 4000 (assisted living with dementia care), 4002 (skilled nursing facility), and 4004 (housing). The surveyor was directed to set up in a room off the main lobby.<br><br>On July 28, 2025, from 1:44 p.m. through 2:07 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B. Off the main lobby a sign was posted on the wall, which identified The Crest. LALD/RN-A stated The Crest (housing with no services) was independent living, was separate from the assisted living with dementia care facility, and was four stories high with an underground parking garage. Off another area of the main lobby was a sign posted on the wall, which identified The Fountains (skilled nursing facility), however, The Fountains had a separate entrance to enter from outside the building. The Shores (assisted living with dementia care unit) sign was also posted on the wall and was accessed off the main lobby. The lower level of the main lobby included a restaurant.<br><br>The assisted living with dementia care facility had a capacity of 70 residents. There were 65 residents residing in The Shores (assisted living with dementia care unit) and an unknown number of people residing at The Crest.<br><br>On July 30, 2025, at 10:15 a.m., the Minnesota Department of Health (MDH) engineer surveyor toured the facility with director of maintenance (DM)-M, LALD/RN-A, and executive director (ED)-N. During the facility tour, the MDH engineer surveyor observed the following:<br><br>There were three addresses posted above the door at the main entrance for the assisted living | 0 130 | | |

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| 0 130 | Continued From page 9<br>facility: 4000,4002, and 4004.<br><br>During the facility tour interview, DM-M stated the building addresses were as follows: 4000 assisted living facility, 4002 skilled nursing facility, and 4004 independent living. DM-M stated the plaza (main lobby entrance) did not have an address and was the hub for all three buildings. The front desk for the assisted living facility was located on the main floor in the hub. A restaurant, dining room, and offices were also located in the hub. DM-M stated the main entrance for the 4000 and 4004 buildings led into the plaza with the 4002 building having a separate main entrance.<br><br>Labeled 90-minute fire doors were held open by electromagnetic door holders in the following locations:<br>- Between the plaza and the assisted living facility;<br>- Between the plaza and the independent living facility; and<br>- Between the plaza and the skilled nursing facility.<br><br>DM-M stated during the facility tour interview, there were 2 hour building separations between the plaza and the assisted living facility.<br><br>On July 30, 2025, at 1:45 p.m., CNS-B stated people who resided at The Crest did not sign contracts with The Shores (assisted living with dementia care facility) since it was separate from the assisted living with dementia care facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) Days | 0 130 | | |

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| | 30492 | A. BUILDING: _____ B. WING _____ | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ECUMEN DULUTH THE SHORES | 4000 LONDON ROAD DULUTH, MN 55804 |

| (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 |
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| 0 470 | Continued From page 10 | 0 470 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors. | 0 470 | | |

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| 0 470 | Continued From page 11<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 include:<br><br>The licensee held an assisted living license with dementia care license effective September 1, 2024, with an expiration date of August 31, 2025. The facility was licensed for a capacity of 70 and had a current census of 65 residents.<br><br>During the entrance conference on July 28, 2025, at 1:05 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with the current minimum assisted living requirements.<br><br>On July 28, 2025, at 1:26 p.m., CNS-B stated CNS-B reviewed the facility's staffing plan twice per year. CNS-B further stated the licensee scheduled one ULP in the secured unit (required a code entered into keypad to exit the unit) and one ULP in the unsecured unit for the overnight shift.<br><br>The licensee's undated (facility name) Resident Incident/Accident Report indicated in the event of a fall, transfer resident back to a position of safety as directed by the nurse. Reminder: never leave MC (memory care- secured unit) unattended. For the time being, call 911 for assistance in the AL (assisted living- unsecured unit) if you do not have a 2nd team member available. | 0 470 | | |

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| 0 470 | Continued From page 12<br><br>The licensee's Direct Care Staffing Plan and Evaluation dated February 1, 2025, indicated 20 residents in the secured unit needed assistance and the licensee planned for three ULPs for the dayshift, three ULPs for the evening shift, and one ULP for the night shift. 30 residents in the unsecured unit needed assistance and the licensee planned for two plus [sic] ULPs for the day shift, two ULPs for the evening shift, and one ULP for the night shift. During the night shift, a nurse from the skilled nursing facility was available to assist as a second person as needed.<br><br>The licensee's Direct Care Staffing Plan and Evaluation dated July 29, 2025 (one day after survey entrance), indicated 21 residents in the secured unit needed assistance and the licensee planned for three ULPs for the dayshift, three ULPs for the evening shift, and one ULP for the night shift. 28 residents in the unsecured unit needed assistance and the licensee planned for two plus [sic] ULPs for the day shift, two ULPs for the evening shift, and one ULP for the night shift. During the night shift, in the event of a fall (in the unsecured unit) staff were trained to call 911 to assist until internal campus process can be resolved.<br><br>The licensee's staffing plan lacked evidence the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.<br><br>On July 29, 2025, at 1:23 p.m., CNS-B stated the licensee previously had nurses from the attached skilled nursing facility to come assist with a fall or two person transfer during the night shift on the | 0 470 | | |

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| 0 470 | Continued From page 13<br><br>unsecured unit, however, the licensee had since implemented to call 911 to assist with a fall or two person transfer due to additional training skilled nursing facility staff would have needed. CNS-B further stated the licensee had only had to call 911 once for assistance since the licensee implemented the change.<br><br>On July 29, 2025, at 3:07 p.m., CNS-B stated the licensee was in the process of working on a sufficient staffing plan without the need to contact 911 for non-emergencies.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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 | 0 480 | | |

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| 0 480 | Continued From page 14<br><br>correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<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 prepared and served according to the Minnesota | 0 480 | | |

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| 0 480 | Continued From page 15<br>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, 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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision. | 0 510 | | |

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| 0 510 | Continued From page 16<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of four employees (unlicensed personnel (ULP)-F, ULP-J). In addition, the licensee failed to ensure infection control standards were followed to disinfect shared reusable resident equipment for one of one employee (ULP-H).<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 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).<br><br>The findings include:<br><br>During the entrance conference on July 28, 2025, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided assistance with ADLs (activities of daily living) to residents at the facility.<br><br>HAND HYGIENE WITH GLOVE USE<br>ULP-J's Relias (on-line training platform) Transcript dated July 29, 2025, indicated ULP-J completed Infection Control Basics on June 25, 2025.<br><br>On July 29, 2025, from 7:10 a.m. through 7:49 a.m., the surveyor observed ULP-F and ULP-J | 0 510 | | |

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| 0 510 | Continued From page 17<br><br>complete morning cares for R4. With gloved hands, ULP-F removed an external catheter from R4's brief, placed the catheter into the garbage can, ULP-F removed ULP-F's gloves, and without performing hand hygiene ULP-F put on new gloves. With gloved hands, ULP-J removed R4's brief, cleansed R4's peri area, and with the same gloved hands had R4 hold ULP-J's gloved hand to roll onto R4's side. With gloved hands, ULP-F cleansed R4's peri area, and with the same gloved hands placed a new brief and pad under R4. With the same gloved hands, ULP-F and ULP-J rolled R4 side to side to position R4's brief and hoyer (mechanical device used to transfer resident) sling under R4. ULP-F and ULP-J removed their gloves, put on a new pair of gloves, rolled R4 to each side one time to put on R4's pants and socks, and transferred R4 into R4's Broda chair. ULP-J removed ULP-J's gloves, put on a new set of gloves, and assisted R4 with brushing R4's teeth. ULP-F removed ULP-F's gloves and made R4's bed. Throughout the observation the surveyor did not observe ULP-F or ULP-J complete hand hygiene in between glove changes.<br><br>On July 29, 2025, at 12:16 p.m., ULP-J stated hand hygiene was supposed to be completed during glove changes, however, ULP-J stated ULP-J did not complete hand hygiene between glove changes this morning. ULP-J further stated ULP-J normally carried hand sanitizer in ULP-J's pocket, however, ULP-J forgot to bring ULP-J's hand sanitizer today due to not usually working the morning shift.<br><br>On July 29, 2025, at 2:30 p.m., ULP-F stated ULPs were trained to complete hand hygiene between gloves changes. | 0 510 | | |

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| 0 510 | Continued From page 18<br><br>On July 30, 2025, at 9:33 a.m., CNS-B stated ULPs were trained to complete hand hygiene before and after glove use. CNS-B further stated ULPs were trained on an annual basis for hand hygiene and CNS-B completed spot check audits on ULP's hand hygiene.<br><br>The licensee's Procedure for Using Gloves policy dated August 1, 2021, indicated to wash hands before applying gloves and after removing gloves.<br><br>The licensee's Hand Hygiene policy dated August 1, 2021, indicated gloves do not replace hand washing. In addition, hands should be washed or decontaminated if moving from a contaminated body site to a clean body site during client (resident) care.<br><br>The licensee's Standard (Universal) Precautions for Infection policy dated August 1, 2021, indicated staff will wash hands after touching body fluid (regardless of whether or not gloves are worn) and immediately after gloves are removed.<br><br>SHARED REUSABLE MEDICAL EQUIPMENT<br>On July 29, 2025, at 9:39 a.m., the surveyor observed ULP-H remove the portable oxygen saturations monitor (monitor used to check oxygen level in the blood) from the basket located in the resident dining room. ULP-H placed the oxygen saturations monitor on R4's finger, completed an oxygen saturation reading, and returned the oxygen saturations monitor back to the basket. The surveyor did not observe ULP-H disinfectant the oxygen saturations monitor before or after use on R4.<br><br>On July 29, 2025, at 10:10 a.m., the surveyor observed ULP-H complete a blood pressure | 0 510 | | |

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| 0 510 | Continued From page 19<br><br>reading for R8 with a shared resident blood pressure cuff. ULP-F removed the blood pressure cuff from the basket located in the resident dining room area, took R8's blood pressure, and returned the blood pressure cuff back to the basket. The surveyor did not observe ULP-F disinfect the blood pressure cuff before or after using the blood pressure cuff on R8.<br><br>On July 29, 2025, at 2:11 p.m., ULP-H stated the licensee's vital sign equipment was shared by all residents at the facility. ULP-H further stated ULP-H was not sure how often the shared vital equipment was cleaned, and ULP-H had thought disinfecting the vital sign equipment was a task for night ULPs to complete. ULP-H stated ULP-H did not disinfectant shared vital sign equipment in between resident use.<br><br>On July 30, 2025, at 9:35 a.m., CNS-B stated shared reusable medical equipment, including the automatic blood pressure cuff, was supposed to be disinfected after each resident use with the licensee's disinfectant wipes.<br><br>The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated August 1, 2021, indicated after using reusable equipment that is for multiple resident use, the equipment must be cleaned and returned to the place that it is stored.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 775 SS=E | 144G.45 Subd. 2. (a) Fire protection and physical environment | 0 775 | | |

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| 0 775 | Continued From page 20<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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>The findings include:<br>On July 30, 2025, at 10:15 a.m., the surveyor toured the facility with director of maintenance (DM)-M, licensed assisted living director/registered nurse (LALD/RN)-A, and executive director (ED)-N. During the facility tour, the surveyor observed the following:<br><br>CONTROLLED EGRESS DOOR LOCKING SYSTEM<br>- Electromagnetic locks were installed on the emergency exit doors in the dementia care unit. Keypads were installed at these doors and required entry of a code into the keypad to unlock. A covered switch was installed above each door. During the facility tour interview, DM-M verified the above listed locking observations. DM-M stated each exit door had a switch that would unlock that door, and these switches would not break power to all of the | 0 775 | | |

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| 0 775 | Continued From page 21<br><br>locked egress doors. DM-M further explained all of the controlled egress doors could be unlocked above the ceiling or with activation of the fire alarm panel. A switch or device was not installed at the nurse station or other approved location that had the capability to break power to all locked egress doors. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511.<br><br>FIRE DOOR MAINTENANCE<br>- The door closer was removed from the labeled fire door for the housekeeping room on the third floor. During the facility tour interview, DM-M verified the fire door observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 775 | | |
| 0 800 SS=E | 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 provide the physical environment in a continuous state of good repair and operation | 0 800 | | |

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| 0 800 | Continued From page 22<br>with regard to the health, safety, and well-being of the 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, 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>The findings include:<br>On July 30, 2025, at 10:15 a.m., the surveyor toured the facility with director of maintenance (DM)-M, licensed assisted living director/registered nurse (LALD/RN)-A, and executive director (ED)-N. During the facility tour, the surveyor observed the following:<br>- The walk-in bathtub was broken in the dementia care spa room.<br>- On the exterior of the facility, there were heaves and cracks in one section of the sidewalk on the side of the building.<br>During the facility tour interview, ED-N verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia | 01530 | | |

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| 01530 | Continued From page 23<br>topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two | 01530 | | |

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| 01530 | Continued From page 24<br><br>employees (registered nurse (RN)-C) received the required amount of dementia care training in the required time frame.<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 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>During the entrance conference on July 28, 2025, at 1:22 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of the required contents of the employee record.<br><br>RN-C was hired on October 18, 2024, to provide supervision of staff and residents at the facility.<br><br>On July 29, 2025, at 1:42 p.m., the surveyor reviewed two medication carts with RN-C.<br><br>RN-C's Relias (online training platform) Transcript dated July 28, 2025, indicated RN-C had completed one and three quarter hours of dementia training from October 28, 2024, through July 15, 2025.<br><br>RN-C's employee record lacked eight hours of dementia training within 120 hours of the employee start date for supervision of direct-care staff.<br><br>On July 30, 2025, at 9:23 a.m., clinical nurse | 01530 | | |

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| 01530 | Continued From page 25<br><br>supervisor (CNS)-B stated RN-C had worked over 120 hours for the licensee since October 18, 2024.<br><br>On July 30, 2025, at 10:38 a.m., CNS-B stated CNS-B had spoke with the training staff and was informed RN-C was incorrectly assigned dementia training, which lead to RN-C not completing a total of eight hours.<br><br>The licensee's Dementia Training policy dated August 1, 2021, indicated supervisors of direct-care staff will complete a minimum of eight hours initial training on dementia care topics. In addition, initial training will be completed within 120 working hours of the employment start date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01710 SS=D | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the | 01710 | | |

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| 01710 | Continued From page 26<br><br>registered nurse (RN) reassessed residents for appropriate medication management services when resident status changed for one of four residents (R4) who received medication management 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 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>During the entrance conference on July 28, 2025, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility.<br><br>R4's diagnoses included hypertension (HTN-high blood pressure), weakness, and shortness of breath.<br><br>R4's service plan dated June 27, 2025, indicated services included medication administration.<br><br>R4's prescriber orders dated July 23, 2025, included an order for albuterol HFA (for shortness of breath) 90 micrograms (mcg) inhaler take 1-2 puffs by mouth twice per day as needed. May keep at bedside.<br><br>R4's Medication Administration Record dated July 2025, indicated R4 was administered albuterol HFA was self-administered once on July 23, 2025. | 01710 | | |

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| 01710 | Continued From page 27<br><br>On July 29, 2025, at 7:40 a.m., the surveyor observed R4's albuterol HFA 90 mcg inhaler sitting on a side table in R4's room with unlicensed personnel (ULP)-F. ULP-F stated R4 used to self-administer R4's inhaler, however, ULP-F was not sure if R4 still self-administered the albuterol inhaler.<br><br>R4's AL (assisted living) Nursing Assessment dated July 1, 2025, indicated R4 required assist with medication administration and R4 did not plan to self-administer any medications. The assessment included the following question: based on the above evaluation, can resident safely self-administer medications without assistance, however, the question was not answered.<br><br>R4's record lacked evidence R4 was assessed for self-administration of albuterol HFA as needed.<br><br>On July 30, 2025, at 12:38 p.m., CNS-B stated R4 was not assessed to self-administer albuterol HFA inhaler according the R4's assessment, and R4 required assistance for all medication administration.<br><br>The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated August 1, 2021, indicated the RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include documentation of specific resident instructions relating to the administration of medications. The medication management record will be current and updated when there are any changes. | 01710 | | |

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| 01710 | Continued From page 28<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01710 | | |
| 01730 SS=E | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to | 01730 | | |

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| 01730 | Continued From page 29<br><br>documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of four residents (R4, R6).<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>During the entrance conference on July 28, 2025, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. | 01730 | | |

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| 01730 | Continued From page 30<br><br>R4<br>R4's diagnoses included hypertension (HTN-high blood pressure), weakness, and shortness of breath.<br><br>R4's service plan dated June 27, 2025, indicated services included medication administration.<br><br>R4's prescriber orders dated July 23, 2025, included two antihypertensives, two to treat acid reflux, three to treat pain, two for shortness of breath, one antidepressant, one for hypothyroidism, and one for anxiety.<br><br>On July 29, 2025, at 7:40 a.m., the surveyor observed R4's albuterol HFA 90 micrograms (mcg) inhaler sitting on a side table in R4's room with unlicensed personnel (ULP)-F. ULP-F stated R4 used to self-administer R4's inhaler, however, ULP-F was not sure if R4 still self-administered the albuterol inhaler.<br><br>R4's AL (assisted living) Nursing Assessment dated July 1, 2025, indicated R4 required assist with medication administration and medications were stored in a locked medication cart.<br><br>R6<br>R6's diagnoses included HTN, pulmonary fibrosis (difficult to breathe), and congestive heart failure (CHF).<br><br>R6's service plan dated July 24, 2025, indicated services included medication administration.<br><br>R6's prescriber orders dated July 21, 2025, included one medication to treat pulmonary fibrosis. | 01730 | | |

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| 01730 | Continued From page 31<br><br>On July 29, 2025, at 8:44 a.m., the surveyor observed ULP-K administer R6's scheduled morning medication. During the observation, the surveyor observed a bottle of Ofev (to treat pulmonary fibrosis) 150 milligrams (mg) sitting on the end table next to R6's chair. R6 stated R6 self-administered Ofev twice per day.<br><br>R6's AL (assisted living) Nursing Assessment dated July 24, 2025, indicated R6 required assist with medication administration, R6 was able to self-administer the medication to treat pulmonary fibrosis, and medications were stored in a locked medication cart.<br><br>R4 and R6's individualized medication management plans listed on the AL (assisted Living) Nursing Assessments did not match current medication storage for each resident.<br><br>On July 30, 2025, at 12:38 p.m., CNS-B stated R4 and R6's medication management plans were not updated to reflect the current medication storage for each resident and medication storage must have been overlooked when the assessments were completed.<br><br>The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated August 1, 2021, indicated the RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. The medication management record will be current and updated when there are any changes. | 01730 | | |

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| 01730 | Continued From page 32<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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.<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 administered per prescriber orders for two of four residents (R4, R6) observed during medication administration. In addition, the licensee failed to accurately transcribe the prescriber orders onto the electronic medication administration record (EMAR) for one of four residents (R3).<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 | 01760 | | |

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| 01760 | Continued From page 33<br><br>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>During the entrance conference on July 28, 2025, at 1:12 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility.<br><br>MEDICATION ADMINISTRATION ERROR<br>R4<br>R4's diagnoses included hypertension (HTN-high blood pressure), weakness, and shortness of breath.<br><br>R4's service plan dated June 27, 2025, indicated services included medication administration.<br><br>R4's prescriber orders dated July 23, 2025, included an order for levothyroxine (for thyroid) 25 micrograms (mcg)- take one tablet by mouth once daily.<br><br>R4's Medication Administration Record dated July 2025, indicated R4 received levothyroxine 25 mcg tablet by mouth once daily scheduled at 7:00 a.m.<br><br>On July 29, 2025, at 9:35 a.m., the surveyor observed unlicensed personnel (ULP)-H administer scheduled morning medication for R4. The surveyor observed ULP-H administer R4's levothyroxine 25 mcg tablet along with all medications scheduled for 7:00 a.m. and 8:00 a.m., at the dining room table. The surveyor observed R4 had consumed R4's breakfast prior | 01760 | | |

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| 01760 | Continued From page 34<br>to the administration of levothyroxine 25 mcg.<br><br>On July 29, 2025, at 2:06 p.m., ULP-H stated R4's medication administration record would have indicated to give R4's levothyroxine earlier than other medications, however, most residents were administered their levothyroxine at the same time as other medications per the resident's preference.<br><br>R6<br>R6's diagnoses included HTN, pulmonary fibrosis (difficult to breathe), and congestive heart failure (CHF).<br><br>R6's service plan dated July 24, 2025, indicated services included medication administration.<br><br>R6's prescriber orders dated July 23, 2025, included an order for levothyroxine 200 mcg- take one tablet by mouth once daily.<br><br>R6's Medication Administration Record dated July 2025, indicated R6 received levothyroxine 200 mcg tablet by mouth once daily scheduled at 9:00 a.m., along with all other scheduled morning medications.<br><br>On July 29, 2025, at 8:44 a.m., the surveyor observed ULP-K administer R6's scheduled morning medication. The surveyor observed ULP-K administer R6's levothyroxine 200 mcg along with other scheduled medications at 9:00 a.m.<br><br>On July 29, 2025, at 9:19 a.m., ULP-K stated R6 received R6's levothyroxine with all other morning medications scheduled for 9:00 a.m.<br><br>On July 30, 2025, at 9:31 a.m., CNS-B stated | 01760 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ECUMEN DULUTH THE SHORES | 4000 LONDON ROAD DULUTH, MN 55804 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01760 | Continued From page 35<br><br>ULPs were to administer resident's scheduled levothyroxine as ordered on the medication administration record. CNS-B further stated levothyroxine was to be administered one hour before other medications unless the licensee obtained an order from the prescriber which indicated levothyroxine could be administered at the same time as other medications.<br><br>The manufacturer instructions for levothyroxine dated August 2022, indicated to administer levothyroxine on an empty stomach, one-half to one hour before breakfast.<br><br>The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated August 1, 2021, indicated medications will be administered including the right time. In addition, the registered nurse (RN) has developed written, specific instruction for each client (resident).<br><br>TRANSCRIPTION ERROR<br>R3's diagnoses included HTN, muscle weakness, and unspecified convulsions (involuntary shaking).<br><br>R3's service plan dated July 29, 2025, indicated services included medication administration.<br><br>R3's prescriber orders dated July 21, 2025, included an order for famotidine (for acid reflux) 10 milligrams (mg) by mouth one daily.<br><br>R3's Medication Administration Record dated July 2025, indicated R4 was administered famotidine 10 mg by mouth daily at 8:00 a.m., and Pepcid AC (for acid reflux) 10 mg by mouth daily at 8:00 a.m.<br><br>CNS-B provided an email (electronic mail) dated | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30492 | A. BUILDING: _____ B. WING _____ | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ECUMEN DULUTH THE SHORES | 4000 LONDON ROAD DULUTH, MN 55804 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01760 | Continued From page 36<br><br>July 30, 2025, at 12:21 p.m., from R6's pharmacy, which indicated the pharmacy had a dispensing error and had duplicate orders on file for R6 for famotidine 10 mg daily and heartburn relief (famotidine) 10 mg daily. The email further indicated the pharmacy did not catch the duplicate orders, sent two doses of famotidine to be administered daily in different medication cards, and now have discontinued famotidine 10 mg.<br><br>On July 30, 2025, at 12:35 p.m., CNS-B stated R6's famotidine 10 mg and Pepcid AC 10 mg were duplicated orders the licensee did not catch when entered on to R6's medication administration record. CNS-B stated R6 received double the dose for famotidine 10 mg daily and it was considered a medication error for R6.<br><br>The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated August 1, 2021, indicated the RN or appropriate Licensed Health Professional [sic] is responsible for ensuring that current, authorized prescriber prescriptions for medications to be administered by the staff are kept in the resident's record. Changes in orders must be addressed in the resident's Medication Administration Record [sic], if applicable, and should be communicated promptly to all appropriate staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

Ecumen Duluth The Shores
4000 London Road
Duluth, MN 55804
St. Louis County
Parcel:

Phone:

## License Info

License: HFID 30492

Risk:
License:
Expires on:
CFPM: Wade W. Schadewald
CFPM #: 273; Exp: 12/05/2028

## Inspection Info

Report Number: F8010251060
Inspection Type: Follow-up - Single
Date: 8/11/2025 Time: 1:43:25 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

# Food & Beverage General Comment

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION TO THE INSPECTION DONE ON 07/29/2025.

THE THREE PREVIOUS ORDERS HAVE BEEN COMPLETED.

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Duluth District Office inspection report number F8010251060 from 8/11/2025**

Deborah Kosiak

Wade Schadewald
Culinary Director

Deb Kosiak,
Public Health Sanitarian 3
218-302-6176
deb.kosiak@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

# Sanitizer Observations/Recordings



## Establishment Info

Ecumen Duluth The Shores
Duluth
County/Group: St. Louis County

## Inspection Info

Report Number: F8010251060
Inspection Type: Follow-up
Date: 8/11/2025
Time: 1:43:25 PM

**Sanitizing Chemical:** **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Kitchen **Equal To** 400 PPM
Comment:
*Violation Issued?: No*

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

# Food & Beverage Inspection Report



**Establishment Info**

Ecumen Duluth The Shores
4000 London Road
Duluth, MN 55804
St. Louis County
Parcel:

Phone:

**License Info**

License: HFID 30492

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

**Inspection Info**

Report Number: F8010251051
Inspection Type: Full - Single
Date: 7/29/2025 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

**New Order: 3-300C Protection from Contamination: equipment/utensils, consumers**
3-305.11A *Priority Level: Priority 3 CFP#: 39*
*MN Rule 4626.0300A* Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.
COMMENT: KITCHEN WALK-IN FREEZER-THERE WERE FOOD BOXES STORED ON THE FLOOR. REMOVE FOOD BOXES FROM THE FLOOR AND STORE ON SHELVES.
*Comply By: 7/29/2025 Originally Issued On: 7/29/2025*

**New Order: 7-100 Toxic Labeling**
7-102.11 *Priority Level: Priority 2 CFP#: 28*
*MN Rule 4626.1595* Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: KITCHEN AND MEMORY CARE - SPRAY BOTTLES THAT HELD QUATERNARY AMMOMIUM SANITIZERS WERE INCORRECTLY LABELED AS SINK AND SURFACE SANITIZER. ALL WORKING CONTAINERS ARE TO BE CLEARLY LABELED WITH THE NAME OF THE SANITIZER THAT IS IN THE BOTTLES. SPRAY BOTTLES WERE DISCARDED BY STAFF.
*Comply By: Complied On Site Originally Issued On: 7/29/2025*

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
*MN Rule 4626.1620* Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: THE QUATERNARY AMMONIUM SANITIZER FROM THE DISPENSER WAS GREATER THAN THE MAXIMUM CONCENTRATION OF 400 PPM. AS A RESULT THE WIPING CLOTH BUCKETS AMMONIUM SANITIZER WAS GREATER THAN 400 PPM. WATER WAS ADDED TO THE WIPING CLOTH BUCKETS TO LOWER THE CONCENTRATION TO 200 PPM BEFORE USING ON FOOD PREPARATION AREAS. MAKE A SERVICE CALL.
*Comply By: Complied On Site Originally Issued On: 7/29/2025*

# Food & Beverage General Comment

INSPECTED MAIN KITCHEN AND MEMORY CARE UNIT
MEMORY CARE UNIT-FOOD IS PREPARED AND HELD HOT OR COLD IN THE MAIN KITCHEN, TRANSPORTED TO MEMORY CARE UNIT AND IS SERVED IMMEDIATELY. ALL EQUIPMENT AND UTENSILS USED IN THE MEMORY CARE UNIT ARE WASHED AND SANITIZED IN THE MAIN KITCHEN DISHWASHER.

REVIEWED THE ILLNESS LOG SHEET THAT WAS ON SITE AND DISCUSSED THE EXCLUSION OF EMPLOYEES ILL

WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

FACT SHEETS DISTRIBUTED TO STAFF:
HIGHLY SUSCEPTIBLE POPULATION
HANDWASHING SIGNS
ILLNESS LOG SHEET
TEMPERATURE AND TIME REQUIREMENTS FOR FOOD

**NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

**I acknowledge receipt of the Duluth District Office inspection report number F8010251051 from 7/29/2025**

Deborah Kosiak

Wade Schadewald
Culinary Director

Deb Kosiak,
Public Health Sanitarian 3
218-302-6176
deb.kosiak@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

# Temperature Observations/Recordings



## Establishment Info

Ecumen Duluth The Shores
Duluth
County/Group: St. Louis County

## Inspection Info

Report Number: F8010251051
Inspection Type: Full
Date: 7/29/2025
Time: 10:30:00 AM

**Food Temperature: Product/Item/Unit:** SLICE TOMATOES**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler/TOP at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** ALFREDO**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler/TOP at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** SLICE BEEF**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler/BOTTOM at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** COLE SLAW**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CHICKEN SALAD**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** PENNE**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 167 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** CHICKEN**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 163 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** MASHED POTATOES**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 162 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** BEEF GRAVY**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 167 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** CHICKEN**; Temperature Process:** Hot-Holding
**Location:** Hot Box at 174 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** PENNE**; Temperature Process:** Hot-Holding
**Location:** Hot Box at 147 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** CHICKEN NOODLE SOUP**; Temperature Process:** Hot-Holding
**Location:** Hot Box at 174 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** CHICKEN NOODLE SOUP**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 193 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** MAC & CHEESE**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 35 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** WHITE RICE**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 36 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** SALMON**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 36 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** FOODS FROZEN**; Temperature Process:** Cold-Holding
**Location:** Walk-in Freezer at  Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature**: **Product/Item/Unit:** FOODS FROZEN**; Temperature Process:** Cold-Holding
**Location:** Under Counter Freezer at  Degrees F.
Comment:
*Violation Issued?: No*

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

# Sanitizer Observations/Recordings



## Establishment Info

Ecumen Duluth The Shores
Duluth
County/Group: St. Louis County

## Inspection Info

Report Number: F8010251051
Inspection Type: Full
Date: 7/29/2025
Time: 10:30:00 AM

**Sanitizing Chemical:** **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
**Location:** Dishwashing Area **Greater Than** 400 PPM
Comment:
*Violation Issued?: Yes*

**Sanitizing Chemical:** **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Prep Area **Greater Than** 400 PPM
Comment:
*Violation Issued?: Yes*

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Dishwashing Area **Equal To** 160 Degrees F.
Comment: TEMP TAPE TURNED BLACK
*Violation Issued?: No*

Minnesota (MDH) Version
EH Manager; RPT: F8010251051

# Food Establishment Inspection Report



Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

| | | |
|---|---|---|
| No. of Risk Factor/Intervention/Violations | 0 | Date: 7/29/2025 |
| No. of Repeat Risk Factor/Intervention/Violations | | Time: 10:30 AM |
| Score (optional) | | Dur: min |

| Establishment: | Address: | City/State: | Zip: | Phone: |
|---|---|---|---|---|
| Ecumen Duluth The Shores | 4000 London Road | Duluth, MN | 55804 | |
| **License/Permit #:** | **Permit Holder:** | **Purpose of Inspection:** | **Est. Type:** | **Risk Category:** |
| HFID 30492 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

**IN**=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

**COS**=corrected on-site during inspection **R**=repeat violation

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Supervision** | | | |
| 1 | IN | Person in charge present, demonstrate knowledge and performs duties | | |
| 2 | IN | Certified Food Protection Manager | | |
| | **Employee Health** | | | |
| 3 | IN | knowledge, responsibiities, and reporting | | |
| 4 | IN | Proper use of restriction and exclusion | | |
| 5 | IN | Response to vomiting, diarrheal events | | |
| | **Good Hygienic Practices** | | | |
| 6 | IN | Proper eating, tasting, drinking, tobacco use | | |
| 7 | IN | No discharge from eyes, nose, and mouth | | |
| | **Preventing Contamination by Hands** | | | |
| 8 | IN | Hands clean and properly washed | | |
| 9 | IN | No bare hand contact with RTE foods, alternatives | | |
| 10 | IN | Adequate handwashing sinks supplied and access | | |
| | **Approved Source** | | | |
| 11 | IN | Food obtained from approved source | | |
| 12 | N/O | Food Received at proper temperature | | |
| 13 | IN | Food in good condition, safe & unadulterated | | |
| 14 | N/A | Records available: shellstock tags, parasite dest. | | |
| | **Protection From Contamination** | | | |
| 15 | IN | Food separated and protected | | |
| 16 | IN | Food-contact surfaces; cleaned & sanitized | | |
| 17 | IN | Proper Disposition of returned, previously served, reconditioned,& unsafe food | | |

| | Compliance Status | | COS | R |
|---|---|---|---|---|
| | **Time/Temperature Control for Safety** | | | |
| 18 | N/O | Proper cooking time & temperatures | | |
| 19 | N/O | Proper reheating procedures for hot holding | | |
| 20 | N/O | Proper cooling time and temperature | | |
| 21 | IN | Proper hot holding temperatures | | |
| 22 | IN | Proper cold holding temperatures | | |
| 23 | IN | Proper date marking & disposition | | |
| 24 | N/A | Time as public health control;procedures & record | | |
| | **Consumer Advisory** | | | |
| 25 | N/A | Consumer advisory provided for raw or undercooked foods | | |
| | **Highly Susceptible Populations** | | | |
| 26 | IN | Pasteurized foods used; prohibited foods not offered | | |
| | **Food/Color Additives and Toxic Substances** | | | |
| 27 | N/A | Food additives; approved & properly used | | |
| 28 | OUT | Toxic substances properly identified;stored;used | X | |
| | **Conformance with Approved Procedures** | | | |
| 29 | N/A | Compliance with variance, specialized processes & HACCP plan | | |

**Risk factors** are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

## GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

| | | | COS | R |
|---|---|---|---|---|
| | | **Safe Food and Water** | | |
| 30 | IN | Pasteurized eggs used where required | | |
| 31 | | Water & ice from approved source | | |
| 32 | N/A | Variance obtained for specialized processing methods | | |
| | | **Food Temperature Control** | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | N/O | Plant food properly cooked for hot holding | | |
| 35 | IN | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| | | **Food Identification** | | |
| 37 | | Food properly labeled; original container | | |
| | | **Prevention of Food Contamination** | | |
| 38 | | Insects, rodents, & animals not present; no unauthorized person | | |
| 39 | X | Contamination prevented during food prep, storage, & display | | |
| 40 | | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| | | **Proper Use of Utensils** | | |
| 43 | | In-use utensils; Properly stored | | |
| 44 | | Utensils, equipment & linens; properly stored, dried, handled | | |
| 45 | | Single-use & single-service articles, properly stored and used | | |
| 46 | | Gloves used properly | | |
| | | **Utensils, Equipment and Vending** | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | | Warewashing facilities: installed, maintained, used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities; properly constructed, supplied & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing and plan review | | |

Person in Charge (signature)

Inspector (signature) Deborah Kosiak

Follow-up: Follow-up Date: