



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 16, 2022

Administrator
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN 56378

RE: Project Number(s) SL28803015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

The total amount you are assessed is \$500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:

Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

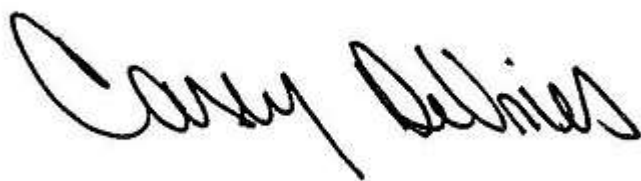
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to

Health.HRD.Appeals@state.mn.us.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2022
NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28803015-0 On July 25, 2022, through July 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 470	Continued From page 2 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 the residents). The findings include: STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility - ensured 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 - ensured 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. On July 27, 2022, at 9:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-B confirmed a staffing plan had not been developed. OVERNIGHT STAFFING On July 25, 2022, at 1:00 p.m., owner (O)-A stated staff work 24-hour shifts and sleep during the overnight hours. O-A stated all residents are independent with ambulation and can make their needs known. There are no overnight services, no lifts, no transfers, and because the facility is a small house, staff can easily hear what is going	0 470		

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0 470	Continued From page 3 on. On July 25, 2022, at 2:30 p.m., LALD/RN-B stated they have awake overnight staff scheduled for tonight and are working on the schedule going forward. They have a staff meeting scheduled for July 27, 2022, to discuss the staffing schedule. On July 27, 2022, at 9:30 a.m., LALD/RN-B stated they had been looking at the 2021 statute book and were going by the exemption for facilities with fewer than 12 residents and thought they could have asleep overnight staff. They were not aware the exemption had been repealed. The staffing schedule was changed immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480			

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0 480	Continued From page 4 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 25, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 5 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn while working in the facility for all staff observed for universal COVID-19 precautions. The licensee further failed to ensure residents, staff, and visitors were screened for COVID-19. This had the potential to affect all four 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 the residents). The findings include: On July 25, 2022, at 10:00 a.m., upon entrance to the facility, licensee's staff did not screen the surveyor for COVID-19 nor did the surveyor observe any signage prompting self-screening. The surveyor observed the lack of face masks and eye protection for owner (O)-A and licensed assisted living director/registered nurse (LALD/RN)-B. On July 25, 2022, at 1:00 p.m., LALD/RN-B	0 510		

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0 510	Continued From page 6 stated they had just been screening residents if they had been exposed or were not feeling well. LALD/RN-B stated she was sure she had gotten an email stating they no longer had to wear masks or screen for COVID. LALD/RN-B and O-A immediately added daily screening for residents and staff and screening for visitors in addition to wearing masks and eye protection. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) and Source Control Grids for Congregate Care Settings, by Community Transmission Level dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a facemask and eye protection. The licensee's January 7, 2017, Standard (Universal) Precautions for Infection Control Policy lacked updated information to include direction related to COVID-19. The Centers for Disease Control and Prevention (CDC) transmission level tracker dated July 25, 2022, indicated the facility's community transmission level was high. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who	0 550			

Minnesota Department of Health

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0 550	Continued From page 7 are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posting of the grievance procedure, and the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	0 550		

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0 550	Continued From page 8 On July 25, 2022, at 10:15 a.m., the surveyor observed the common areas within the facility and noted there was no required posting of the grievance procedure and contact information for the state and applicable regional Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B confirmed the required content noted above was not currently posted as required. LALD/RN-B stated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

Minnesota Department of Health

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0 580	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 25, 2022, at 10:00 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-B stated they did have quality management meetings on a regular basis but was not sure where the documentation was. LALD/RN-B was not able to find the documentation of the facility quality management activities. The licensee's undated Quality Management Plan policy indicated, retention of documents of the Quality Council will be retained in the agency files for two years and will be made available to the Minnesota Department of Health upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

Minnesota Department of Health

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0 640	Continued From page 10	0 640			
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 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include:	0 640			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378		
(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
0 640	Continued From page 11 On July 25, 2022, at 10:15 a.m., the surveyor observed the common areas within the facility and noted there was no required posting of information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center. On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B confirmed the required content noted above was not currently posted as required. LALD/RN-B stated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 12 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee, (unlicensed personnel (ULP)-C). 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-C began employment on March 25, 2020, to provide direct care services to the licensee's residents. ULP-C's employee record lacked the following: -records of orientation, required annual training,	0 650		

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0 650	Continued From page 13 infection control training and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -documentation of annual performance reviews that identified areas of improvement needed and training needs; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On July 26, 2022, at 12:15 p.m., unlicensed personnel (ULP)-C affirmed the following: -the licensee provided orientation training; -orientation to each resident included shadowing another ULP, was introduced, observed, and read the care plan; -the licensee provided dementia training, which was online through RN.org; -the licensee provided annual training, the owner and the RN meet every few months to cover annual training; -the licensee provided a job description; it was with her application, and she signed it; -the two-step Mantoux was completed at a local clinic and a history and symptom screen was completed upon hire; -a copy of the TB screening is available online; -the licensee conducts annual performance reviews; -the licensee provided training and she had to demonstrate competency; - the licensee provided training on the procedure for packaging medications for residents who will be away; and -the licensee completed a 30-day supervision. On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse	0 650			

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0 650	Continued From page 14 (LALD/RN)-B affirmed the following: -training was completed for ULP-C including competency testing and dementia training; -training is online using RN.org; -orientation to residents is completed by shadowing another ULP, reading the resident chart, and reading resident history; -position descriptions are given to all staff; -the owner (O)-A does the annual performance reviews; -30-day supervisions are completed for ULP's; -staff go to the local clinic for the two step Mantoux and the licensee completes a history and symptom screening upon hire and yearly; and -she is not sure what happened to the paperwork in ULP-C's chart but knows everything was completed. The licensee's Personnel Records policy dated January 7, 2017, indicated personnel records will be kept up to date, well organized and confidential and will comply with the home care law and other relevant laws. The personnel record for each person will include: record of home care orientation, record of all required training for unlicensed personnel and competency determinations, record of required in-service education for all staff providing home care services to clients, TB screening results, results of supervision observations, performance evaluations which identify areas of improvement needed and training needs [performance reviews must be conducted at least annually] current job description, which includes qualifications, responsibilities and identifications of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 650		

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0 650	Continued From page 15 (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 660		

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0 660	Continued From page 16 The findings include: On July 25, 2022, during the 10:00 a.m., entrance conference, licensed assisted living director/registered nurse (LALD/RN)-B stated they had facility TB risk assessment. The surveyor requested to review the TB facility risk assessment. On July 26, 2022, at 11:30 a.m., the surveyor again requested the TB facility risk assessment. On July 27, 2022, at 9:45 a.m., LALD/RN-B stated they did not have a TB facility risk assessment completed. The licensee's TB Prevention and Control policy dated January 7, 2017, indicated the agency will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The Minnesota Department of Health guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings (see 06-009) will be followed. RN or director is responsible for establishing and maintaining the TB prevention and control program. Responsibilities include completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health (see 06-009). The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with	0 660		

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0 660	Continued From page 17 patients [residents] after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680			

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0 680	Continued From page 18 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to prominently post the facility's emergency disaster plan. This had the potential to affect all residents, staff and visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On July 25, 2022, at 10:15 a.m., the surveyor observed the common areas within the facility and noted there was no required posting regarding the licensee's emergency and disaster plan. On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B confirmed the facility emergency disaster plan was not currently posted as required. LALD/RN-B stated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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

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0 780	Continued From page 20 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). Findings include: 1) During the facility tour on July 26, 2022, at approximately 10:30 a.m. with the Registered Nurse (RN)-B, it was observed that the smoke alarms throughout the entire facility were not interconnected so that the actuation of one would cause all alarms to operate. 2) During the facility tour on July 26, 2022, between 09:30 a.m. and 11:45 a.m. with the RN-B, it was observed that there was no smoke alarm in the bedrooms and the hallway of the main floor. RN-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 790		

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0 790	Continued From page 21 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 failed to maintain facility fire extinguishers. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on June 27, 2022, between 09:30 a.m. and 11:45 a.m., survey staff toured the facility with the Registered Nurse (RN)-B, it was observed the fire extinguishers located in the kitchen could not be verified when it was purchased and or serviced. RN-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 22 (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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 26, 2022, between 09:30 a.m. and 11:45 a.m., survey staff toured the facility with a Registered Nurse (RN)-B. During the facility tour, survey staff observed the following: 1. The resident bathroom on the main floor has no cold water and toilet runs an excessive amount of time. 2. The resident bathroom on the main floor has no exhaust fan and has a towel for the grab bars. 3. The resident bathroom on the main floor and second floor bathroom flooring was heavily damaged and coming up from the floor around the toilet.	0 800		

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0 800	Continued From page 23 4. An outlet cover was missing in the hallway outside of room 1. 5. Upstairs sink was clogged when tested, unclogged by RN-B and continued to drain slowly. 6. Room 3 is missing the window screen. 7. The deck outside of room 2 has a burn hole of approximately 6 inches in diameter. 8. There is a dent in the wall of the main floor landing of the stairway. 9. Excessive lint was found behind the dryer. 10. Excessive amount of combustibles and furniture were found in the office area blocking the exit from the laundry room and entrance into the office from the outside. 11. The office had an excessive amount of bugs, cobwebs and dirt on the floor. RN-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 24 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This 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, 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	0 810		

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0 810	Continued From page 25 a large portion or all of the residents). On July 26, 2022 between 09:30 a.m. and 11:45 a.m., the Registered Nurse (RN)-B failed to provide documents for review. Documents were reviewed by survey staff on July 26, 2022 between 09:30 a.m. and 11:45 a.m., 1. The licensee failed to provide employee training logs for fire safety and evacuation. 2. The licensee failed to provide the required employee training frequency. 3. The licensee failed to provide documentation of resident evacuation training. Training documentation were requested by survey staff but were not provided. The RN-B verbally confirmed survey staff observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2022
NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378		
(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
0 820	Continued From page 26 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including, the minimum size egress window openings occupied for resident bedrooms, do not create a distinct hazard to residents and staff. This affected one unoccupied and one occupied resident bedroom. 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 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On July 26, 2022, between the hours of 09:30 a.m. and 11:45 a.m., survey staff toured the home with Registered Nurse (RN)-B. At approximately 10:00 a.m., survey staff attempted to open the egress window in room #1. When the crank out window was opened half way, the window was stopped by the eave of the home. Survey staff explained to the RN-B that the window in this bedroom did not meet the minimum size egress window openings required for safe egress. Room #4 resident bedroom window sizes were not verified due to not being provided access at the time of the survey. At least one window in each	0 820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/27/2022
NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378		
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0 820	Continued From page 27 resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms for assisted living facilities. RN-B verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2022
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0 900	Continued From page 28 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 began receiving services on February 23, 2018. R1's Service Plan dated April 1, 2022, indicated the resident received services which included daily medication administration.	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/27/2022
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0 900	Continued From page 29 R1's record lacked an assisted living contract as required. On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B verified R1's record did not include a current assisted living contract. LALD/RN-B stated she did not have any of the residents sign an assisted living contract when the new assisted living licensure came into effect. LALD/RN stated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain current medication orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2022
NAME OF PROVIDER OR SUPPLIER CEDAR COVE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378		
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01820	Continued From page 30 The findings include: On July 26, 2022, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's service plan, dated April 1, 2022, indicated R1 received medication administration services. R1 had diagnoses including hypertension (high blood pressure) and diabetes. R1's pharmacy medication list dated June 19, 2022, included the following scheduled medications: -acetaminophen 500 mg tablet, take 1,000 mg by mouth twice daily PRN (as needed) -aspirin 81 mg Tbec, take 1 tablet (81 mg total) by mouth daily -atenolol 25 mg tablet, take 0.5 tablets (12.5 mg) by mouth in the morning -atorvastatin 20 mg tablet, take 20 mg by mouth daily at bedtime -blood glucose meter -cholecalciferol (vitamin D3) 1,000 unit cap, take 2 capsules (2,000 units total) by mouth daily -citalopram 40 mg tablet, take 0.5 tablets (20 mg) by mouth in the morning -clonazepam 0.5 mg tablet, take 1 tablet (0.5 mg) by mouth if needed each day for anxiety -divalproex sodium 500 mg Tb24, take 1,000 mg by mouth every evening -docusate sodium 100 mg cap, take 100 mg by mouth twice daily -eczema moisturizing cream top -epinephrine 0.3 mg/0.3 mL auto injector, take 0.3 mg by intramuscular route as directed -famotidine 40 mg tablet, take 40 mg by mouth at bedtime -hydrocodone-acetaminophen 7.5-325 mg tablet,	01820		

Minnesota Department of Health

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01820	Continued From page 31 take 1 tablet by mouth twice daily hydroxyzine pamoate 25 mg cap, take 25 mg by mouth four times daily as needed for anxiety -lancets 33 gauge -levetiracetam 750 mg tablet, take one tablet by mouth twice a day -levofloxacin 500 mg tablet, take 1.5 tablets (750 mg) by mouth in the morning for 3 doses -lithium carbonate 300 mg cap, take 1 capsule (300 mg) by mouth at bedtime -omeprazole 20 mg cpdr, take one capsule by mouth once daily -oxybutynin 5 mg tablet -perampanel 6 mg tablet, take 6 mg by mouth daily at bedtime -polyethylene glycol 3350 17 gram pwpk, take 1 packet (17 g) by mouth every other day -pregabalin 50 mg cap, take 50 mg by mouth twice daily -risperidone 0.5 mg tablet, take 1 mg by mouth once daily -tizanidine 4 mg tablet, take 4 mg by mouth at bedtime as needed for sleep -Tradjenta 5 mg tablet, take 1 tablet by mouth one daily -True Metrix blood glucose test strips On July 26, 2022, at 12:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-B stated they had been using residents after visit summaries for doctors' orders. She did not realize they were not signed doctors' orders. LALD/RN-B stated she will make sure to get signed orders from the doctor and that sometimes it is hard to get the doctor's office to fax the orders back to them but will keep trying. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, dated January 7, 2017, indicated the RN	01820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/27/2022
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01820	Continued From page 32 or appropriate licensed health professional is responsible for assuring that current, authorized prescriber prescriptions for medications and orders for treatments and therapies, to be administered by the staff are kept in the client's [resident] record and that changes in orders are addressed in the client's care plan, service plan and medication administration record, if applicable, and are communicated on a timely basis to all appropriate staff. A medication prescription must include the prescriber's manual or electronic signature. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820			



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

Type: Full
Date: 07/25/22
Time: 11:40:59
Report: 7989221145

Food and Beverage Establishment Inspection Report

Page 1

Location:

Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN56378
Stearns County, 73

Establishment Info:

ID #: 0037551
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207321939
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.

3-200A Food Characteristics: approved source

3-201.11A ** Priority 1 **

MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.

DISCONTINUE PURCHASING RAW GROUND BEEF FROM LOCAL MEAT MARKET WITHOUT
USDA STAMP OF INSPECTION

DISCARD: RAW GROUND BEEF AND SUMMER SAUSAGE FROM SCHAEFERS MEAT MARKET IN
SAUK CENTRE

Comply By: 07/25/22

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.

CLOROX WIPES ARE NOT AN ACCEPTABLE SANITIZER- DISCONTINUE USE AND USE
BLEACH/WATER SOLUTION

Comply By: 07/25/22

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.

PROVIDE CHLORINE TEST STRIPS FOR BLEACH SANITIZER THAT IS USED FOR FOOD CONTACT
SURFACES

Type: Full
Date: 07/25/22
Time: 11:40:59
Report: 7989221145
Cedar Cove Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 07/25/22

4-200 Equipment Design and Construction

4-201.11GMN

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

DISCONTINUE SAVING LEFT- OVERS. KITCHEN IS ONLY LICENSED FOR COOK- SERVE MEALS
ALL LEFT OVERS MUST BE DISCARDED.

LEFTOVERS WERE DISCARDED: LASAGNA, CHICKEN BREAST, CHICKEN ALFREDO, PORK WILD RICE

Comply By: 07/25/22

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 40 Degrees Fahrenheit - Location: LASAGNA

Violation Issued: No

Process/Item: Upright Cooler

Temperature: Degrees Fahrenheit - Location:

Violation Issued: No

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

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 7989221145 of 07/25/22.

Certified Food Protection Manager: JESSICA MARTHALER

Certification Number: 108699 Expires: 10/28/24

Signed: _____
Establishment Representative

Signed: Tyffani Maresh
Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989221145

Food Establishment Inspection Report



Minnesota Department of Health
Food, Pools, & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out

2

Date 07/25/22

No. of Repeat RF/PHI Categories Out

0

Time In 11:40:59

Legal Authority MN Rules Chapter 4626

Time Out

Cedar Cove Assisted Living

Address

21596 Cedar Lake Road

City/State

Sauk Centre, MN

Zip Code

56378

Telephone

3207321939

License/Permit #
0037551

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff; knowledge, responsibilities & reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygienic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate procedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

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

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** 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" 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

Compliance Status		COS	R
Safe Food and Water			
30	IN OUT N/A		
Pasteurized eggs used where required			
31			
Water & ice obtained from an approved source			
32	IN OUT N/A		
Variance obtained for specialized processing methods			
Food Temperature Control			
33			
Proper cooling methods used; adequate equipment for temperature control			
34	IN OUT N/A N/O		
Plant food properly cooked for hot holding			
35	IN OUT N/A N/O		
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			
39			
Contamination prevented during food prep, storage & display			
40			
Personal cleanliness			
41			
Wiping cloths: properly used & stored			
42			
Washing fruits & vegetables			

Compliance Status		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 & used			
46			
Gloves used properly			
Utensil Equipment and Vending			
47	X		
Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48	X		
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 & plan review			

Food Recalls:

Person in Charge (Signature)

Date: 07/25/22

Inspector (Signature)