DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 1, 2023

Licensee
Heritage Of Edina Inc.
3456 Heritage Drive
Edina, MN 55435

RE: Project Number(s) SL35018015

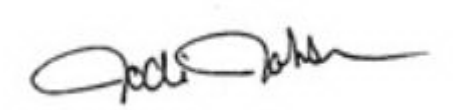
Dear Licensee:

On May 9, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 29, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

Electronically Delivered

April 13, 2023

Licensee
Heritage of Edina Inc
3456 Heritage Drive
Edina, MN 55435

RE: Project Number(s) SL35018015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 29, 2023, 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.

LICENSING ORDERS
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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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. 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,

Jess Schoenecker, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-215-6894 / 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35018	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3456 HERITAGE DRIVE EDINA, MN 55435

(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 ******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: SL35018015 On March 27, 2023, through March 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 48 active residents; 48 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 430		

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0 430	Continued From page 2 The facility converted to an Assisted Living license on August 1, 2021. R1 R1 was admitted for cares and services on March 5, 2019. R1's service plan dated January 26, 2022, indicated R1 received services to include medication administration, bathing, dressing, grooming and transfers. R2 R2 was admitted for cares and services on June 26, 2018. R2's service plan, dated August 11, 2021, indicated R2 received services including assistance with activities of daily living (ADLs), toileting, bathing, dressing, grooming, transfers, housekeeping, laundry, blood glucose management and medication administration. R3 R3 was admitted for cares and services on November 17, 2020. R3's service plan, dated October 26, 2020, indicated R3 received services of medication administration. R4 R4 was admitted for cares and services on July 11, 2022. R4's service plan, dated June 20, 2022, indicated R4 received services including assistance with medication administration, laundry, housekeeping, and blood glucose monitoring.	0 430		

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0 430	Continued From page 3 R1, R2, R3 and R4's records lacked documentation of receipt of the UDALSA. On March 29, 2023, at 1:17 p.m., licensed assisted living director (LALD)-A stated that R1, R2, R3 and R4's records lacked evidence that the resident or resident's representative received a copy of the UDALSA. LALD-A acknowledged that all of the residents or residents' representatives should have received the UDALSA. The licensee's Resident Record Information and Content policy, dated August 1, 2021, included "[Licensee] will maintain appropriate and accurate records for each resident that is receiving assisted living services." and "12. Documentation that the resident has received and reviewed the assisted living bill of rights and UDALSA." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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.	0 480		

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0 480	Continued From page 4 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, March 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 510		

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0 510	Continued From page 5 failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene (HH) for two of four staff (unlicensed personnel (ULP)-I, ULP-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-I ULP-I was hired as an agency home health aide and provided direct care services for residents. On March 28, 2023, at 8:17 a.m., ULP-I was observed providing blood glucose testing and medication administration to R2. Surveyor observed ULP-I perform HH before blood glucose testing. ULP-I completed hand washing in five seconds. After blood glucose testing, ULP-I washed hands for six seconds. ULP-I then administered medications to R2. On March 28, 2023, at 8:27 a.m., ULP-I stated she was given a pamphlet upon hire that went over HH. ULP-I stated that she was trained to wash hands between 30 and seconds and one minute. ULP-I acknowledged that she did not perform HH for 30 seconds between residents during the observation.	0 510		

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0 510	Continued From page 6 ULP-L ULP-L was hired by the licensee on April 9, 2019, as a home health aide and provided direct care services for residents. One March 28, 2023, at 8:30 a.m., ULP-L was observed donning gloves, provided peri-care, and redressed R1's lower body. Without removing gloves, ULP-L dressed R1's upper half by holding R1's hands to guide hands through sleeves. Without removing gloves and washing hands, ULP-L proceeded to search R1's dresser for additional clothing items. ULP-L then replaced gloves without washing hands and assisted with placing a Hoyer (mechanical lift that supports a person's full body weight) sling under R1 for transfer. After transfer, ULP-L removed gloves, washed hands, and assisted R1 to the dining room. On March 28, 2023, at 9:00 a.m., ULP-L confirmed annual training included infection control which included handwashing. On March 28, 2023, at 10:45 a.m., director of nursing (DON)-B stated new employees and staff are trained to wash hands for 20 seconds. Licensed practical nurse (LPN)-E indicated that staff get both in-person and online training on infection control and HH. Licensed assisted living director (LALD)-A confirmed this is how staff are trained. The Centers for Disease Control (CDC) guidance titled, Hand Hygiene in Healthcare Settings, dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves	0 510		

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0 510	Continued From page 7 should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The Licensee's Hand Hygiene Policy, dated March 3, 2017, indicated, "Proper hand hygiene should be used to protect the spread of infection. Hand hygiene shall be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent the spread of infection. Hand washing recommended when your hands are visibly dirty or hand sanitizer, is not being used. 7. Use friction while scrubbing vigorously for at least 15 seconds." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 680		

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0 680	Continued From page 8 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 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 interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all 48 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 of the residents). The findings include: During the entrance conference on March 27, 2023, at 10:00 a.m. the surveyor asked to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor.	0 680		

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0 680	Continued From page 9 The licensee's undated emergency preparedness plan lacked the following required content: a plan for evacuation, sheltering in place, identifies temporary relocation sites, and staff assignments in the event of a disaster or an emergency. On March 28, 2023, at 3:30 p.m., director of nursing (DON)-B confirmed the emergency preparedness program provided to the surveyor, was not completely filled out and lacked the required information. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated September 1, 2022, included "the intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 780		

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0 780	Continued From page 10 (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 so that actuation of one alarm causes all alarms in the dwelling unit to actuate. 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 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: On March 28, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A and the Maintenance Assistant (MA)-D. During the facility	0 780		

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0 780	Continued From page 11 tour, it was observed that the sleeping rooms within the 2-bed room unit that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. During the interview, MA-D confirmed these deficient conditions consistent in every two-bedroom resident unit in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 950 SS=D	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950		

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0 950	Continued From page 12 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, on a separate form, including statutory language, for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 R3 was admitted for cares and services on November 17, 2020. R3's service plan, dated October 26, 2020, indicated R3 received services of medication administration. R3's record lacked documentation of the name and contact information of a designated representative or documentation the resident declined to name a designated representative. On March 29, 2023, at 2:50 p.m., director of nursing (DON)-B stated that they were unable to	0 950		

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0 950	Continued From page 13 find the designated representative form for R3. DON-B only provided R3's old contract prior to August 1, 2021, that didn't include the designated representative documentation. The licensee's Resident Record Information and Content policy, dated August 1, 2021, included "[Licensee] will maintain appropriate and accurate records for each resident that is receiving assisted living services." and "2. The name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	01760		

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01760	Continued From page 14 Based on observation, interview and record review, the licensee failed to ensure the documentation of medications administered included the signature and title of the person who administered the medication. The documentation also lacked each medication name, dosage, date and time administered and method and route of administration for three of four residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). R1 R1's service plan dated January 26, 2022, indicated services to include medication administration. R1's record included a document titled "Med Room Report" dated March 28, 2023, that indicated licensed practical nurse (LPN)-F set up the following medications for later administration: -acetaminophen 325 milligrams (mg), 2 tablets, by mouth, every 4 hours, as needed; -Aricept (for dementia) 10 mg, 1 tablet, by mouth, daily at 8:00 a.m.; -levothyroxine sodium (for low thyroid hormone) 50 micrograms (mcg), 1 tablet, by mouth, daily at 8:00 a.m.; -Lexapro (for agitation) 10 mg, 1 tablet, by mouth daily at 8:00 a.m.; -nystatin powder (for rash), topical, twice daily, as needed;	01760		

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-senna s (for constipation) 1 tablet, by mouth, twice daily, as needed; and
-haloperidol (for agitation) 1 mg, 1 tablet by mouth, once daily, as needed.

On March 28, 2023, at 8:30 a.m., unlicensed personnel (ULP)-L was observed administering medications to R1. ULP-L accessed R1's medication box and opened the medication setup box labeled "Tuesday 8 a.m." The box contained three oral medications, which ULP-L transferred to a paper medication cup. ULP-L brought medications to aide station and crushed medications. ULP-L then brought medications to R1 and administered with applesauce.

On March 28, 2023, at 8:45 a.m., ULP-L stated the nurse sets up the medications and they "just give what's in there." ULP-L stated they had received training on medication administration.

On March 28, 2023, at 9:00 a.m., ULP-L documented medications were administered by initialing on R1's cares documentation sheet next to the task that read, "Pills AM 1: Crush pills mix w/applesauce; administer; observe swallowing; 8:00 AM".

R2
R2's service plan, dated June 20, 2022, indicated R4 received services including assistance with medication administration, and medication set up.

R2's record included a document titled "Med Room Report" dated March 22, 2023, that indicated LPN-F set up the following medications for later administration:
- Aricept (for dementia) 10 mg, one tablet, by mouth, daily at 8:30 p.m.;
- CertaVite Senior (supplement), one tablet by

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mouth, daily at 2:00 p.m.;
- Eliquis (anticoagulant) 2.5 mg, one tablet by mouth, two times per day at 8:00 a.m. and 8:30 p.m.;
- famotidine (for gastric symptoms) 20 mg, one tablet by mouth, daily at 8:00 a.m.;
- Gabapentin (for nerve pain) 100 mg, two capsules by mouth, two times per day at 8:00 a.m. and 8:30 p.m.;
- insulin glargine (long-acting insulin) 18 units, subcutaneous, every morning;
- Lantiseptic ointment (for dry skin), topical at 8:00 a.m. and 8:00 p.m.;
- lisinopril (for blood pressure)10 mg by mouth daily at 8:00 a.m.;
- loperamide (for diarrhea) 2 mg, one capsule by mouth every four hours as needed;
- Reguloid (for constipation) 0.36 grams (g), two capsules by mouth, two times per day at 8:00 a.m., and 8:30 p.m.;
- Senna-S (for constipation) 8.6/50 mg, two tablets by mouth two times per day as needed;
- sertraline (for depression) 50 mg, three and one half tablets by mouth, daily at 8:00 a.m.;
- simvastatin (for cholesterol) 20 mg, one tablet by mouth, daily at 8:30 p.m.;
- Tradjenta (for diabetes) 5 mg, one tablet by mouth, daily at 8:00 a.m.;
- Tylenol (for pain) 325 mg, two tablets by mouth, daily as needed; and
- Tylenol (for pain) 325 mg, two tablets by mouth, three times per day at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

On March 28, 2023, at 8:13 a.m., ULP-I was observed administering medications to R2. ULP-I accessed R2's locked medication box and opened the medication setup box labeled "Tuesday 8 a.m." ULP-I transferred medication from this box into a paper medication cup. ULP-I

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01760	Continued From page 17 provided a glass of water and observed R2 swallow the medications. On March 28, 2023, at 8:15 a.m., ULP-I documented medications were administered by initialing on R2's flowsheet next to the task that read, "Pills AM 1: Administer; observe swallowing; 8:00 AM". R4 R4's service plan, dated June 20, 2022, indicated R4 received services including assistance with medication administration, and medication set up. R4's record included a document titled "Med Room Report" dated March 27, 2023, that indicated LPN-F set up the following medications for later administration: -amlodipine besylate (for high blood pressure) 10 mg, 1 tablet, by mouth, daily At 8:00 a.m.; -aspirin 81 mg, 1 tablet, by mouth, daily at 8:00 a.m.; -divalproex (for dementia) 250 mg extended release (ER), 3 tablets, by mouth, daily at 8:00 a.m.; -duloxetine (for dementia) hydrochloride (HCL) 20 mg, 2 capsules, by mouth daily at 8:00 a.m.; -glipizide (for diabetes) 5 mg, 1 tablet, by mouth, daily at 8:00 a.m.; -glucose tablets (for diabetes) 15 g, 4 tablets by mouth, as needed; -haloperidol (for agitation) 1 mg, 1 tablet by mouth, once daily, as needed; -Lantus (insulin glargine - a long-acting insulin, for diabetes), 100 units/ml, 10 units subcutaneously, daily at 8:00 a.m.; -losartan (for blood pressure) 50 mg, 0.5 tablets by mouth daily at 8:00 a.m.; -metoprolol succinate (for blood pressure) 50 mg, 0.5 tablets by mouth daily at 8:00 a.m.;	01760		

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-mirtazapine (sleep aid) 15 mg, 0.5 tablets by mouth nightly at 8:00 p.m.;
-Tylenol (for pain) 325 mg, 2 tablets by mouth twice daily, as needed; and
-Tylenol 325 mg, 2 tablets by mouth twice daily at 8:00 a.m. and 8:00 p.m.

On March 28, 2023, at 7:50 a.m., ULP-H was observed administering medications to R4. ULP-H accessed R4's medication box and opened the medication setup box labeled Tuesday 8 a.m. The box contained multiple oral medications, which ULP-H transferred to a paper medication cup and administered to R4 with water.

On March 28, 2023, at 7:52 a.m., ULP-H stated she did not know how many pills there should be, or what medications were included. ULP-H stated the nurse sets them up and she trusted the accurate number of pills were there. ULP-H further stated she had training and knew the "6 rights" of medication administration.

On March 28, 2023, at 7:55 a.m., ULP-H documented medications were administered by initialing on R4's cares documentation sheet next to the task that read, "Pills AM 1: Administer; observe swallowing; 8:00 AM".

R1, R2, and R4's record lacked documentation of medication administration, to include: including: medication name, medication dosage, medication time to be administered, and the method and route of medication administration.

On March 29, 2023, at 1:00 p.m., interview with director of nursing (DON)-B and licensed assisted living director (LALD)-A on the current process of ULP's medication administration using medication

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01760	Continued From page 19 set up box, initialed on flowsheet the time the medications were administered out of the set up box. DON-B stated they have always set up the medications this way and then the ULP administers what is in the medication set up box for a specific time. DON-B stated they have one person, LPN-F that is setting up medications weekly, and both DON-B and LALD-A indicated this is the most accurate way for the licensee to administer medication. DON-B acknowledged that the ULP is only documenting for administering the medications at specific times and are not documenting each medication separately that included name of medication, dosage, route, date, time, name and title of the person who administered medication. The licensee's Medication Management Services Provided by HHA policy, dated August 1, 2021, included "Medication Management Services provided by a HHA to residents of [licensee] will be performed consistent with Minnesota Comprehensive Home Care Rules, including prior training and competency testing and the residents' individualized medication management plan." and "5. The case manager will instruct the HHA on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's flowsheet administration record (MAR)." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 20 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability 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 a large portion or all of the residents). Findings include: A record review of the available documentation and interview was conducted on March 28, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)-A and the Maintenance Assistant (MA)-D on the hazard	02040		

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02040	Continued From page 21 vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, LALD-A stated that they have regular safety meetings to discuss building safety issues. The record of the meeting provided by email the following day by LALD-A did not include provisions for a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02090 SS=C	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to maintain a dignified dining experience by using appropriate tableware in the dining room. This had the potential to affect all of the licensee's residents. 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	02090		

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02090	Continued From page 22 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 March 27, 2023, at 11:41 a.m., during a facility tour, residents were eating in the main dining room. All residents were observed with their meals in Styrofoam, clamshell, take-out style containers, plastic utensils, and disposable Styrofoam and plastic cups. Each resident's meal was sitting on the table on a serving tray. Three staff were observed, each standing next to residents, assisting them with eating their meal. On March 27, 2023, at 11:44 a.m., surveyors observed a separate dining area in the East unit where residents were also eating. Food was served in disposable Styrofoam containers, with disposable utensils and drinkware. All meals were sitting on serving trays. Two staff were observed sitting with residents, assisting them with eating. On March 27, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated food was made in the sister-facility next door, and brought to their building where food was plated for serving. LALD-A stated they were having trouble with staffing in dietary, and were using disposable tableware to save time. LALD-A further stated they had been doing so off and on for about a year. On March 27, 2023, at 2:04 p.m., unlicensed personnel (ULP)-O stated they had been using disposable tableware since she started working there in November (approximately 4 months prior). ULP-O further stated the meals were always kept on the serving trays on the table.	02090		

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02090	Continued From page 23 On March 27, 2023, at 2:19 p.m., dietary aid (DA)-J stated they had been using disposable tableware for about the past year. DA-J stated she was working by herself and there was not enough time to wash dishes. On March 27, 2023, at 2:30 p.m., director of dietary (DOD)-G stated they had been using disposable tableware most days of the week since the end of October (approximately 5 months) due to a staff shortage. DOD-G stated she felt bad about doing so, especially for meals during the holidays. DOD-G further stated it was difficult to obtain staffing for the long shift, and staff often did not show up for work. The licensee's ALDC Dementia Care Philosophy policy, dated August 1, 2021, indicated the licensee would provide care in a homelike environment, and preserving the dignity of each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02090		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations;	02170		

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	35018	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3456 HERITAGE DRIVE EDINA, MN 55435

(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
02170	Continued From page 24 (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to develop an individualized activity plan for each resident based on their activity evaluation. Further, the licensee failed to include a selection of daily activities on the resident's activity service or care plan for four of four residents (R1, R2, R3, R4) who resided on the dementia care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02170		

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	35018	A. BUILDING: _____ B. WING _____	03/29/2023

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02170	Continued From page 25	02170		

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:

The licensee had a current assisted living with dementia care (ALFDC) license.

R1
R1 had a diagnosis to include dementia.

R1's service plan, dated January 26, 2022, indicated R1 received services of safety checks, bathing, toileting, laundry, meals and medication administration.

R2
R2 had diagnoses including Alzheimer's Disease.

R2's service plan, dated August 11, 2022, indicated R2 received services of bathing, toileting, transfers, meals, housekeeping, laundry, safety checks, blood glucose testing and medication management.

R3
R3 had a diagnosis to include heart failure and dementia.

R3's service plan, dated October 26, 2020, indicated R3 received services of laundry, bathing, and medication administration.

R3's Activity Assessment form dated October 26, 2020, documented the resident "refused to fill out" the form. No additional attempts to discuss

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	35018	A. BUILDING: _____ B. WING _____	03/29/2023

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02170	Continued From page 26 activities of interest with R3 or to complete the form were provided. R4 R4 had diagnoses including dementia. R4's service plan, dated June 20, 2022, indicated R4 received services of laundry, housekeeping, bathing, toileting, and medication administration. R1, R2, R3 and R4's record lacked the development of an individualized activity plan and any evidence R1, R2, R3 and R4 were evaluated for activities according to the licensing rules of the facility to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. On March 29, 2023, at 9:23 a.m., licensed assisted living director (LALD)-A stated they were unable to locate completed activity assessments, and she did not think any kind of activity plan had been documented. LALD-A further stated the activities director would look at the activity assessment and then schedule activities to reflect residents' interests. On March 29, 2023, at 12:28 p.m., director of activities (DA)-N stated she would complete activity evaluations for any residents admitted to the dementia care-licensed facility. DA-N stated she had not been working at the facility for a period of time and activity evaluations had not been consistently completed during that time.	02170		

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02170	Continued From page 27 DA-N stated up to this point with the new licensure, she had not developed an individualized activity plan. DA-N stated she had already been discussing a plan with LALD-A and had been researching evaluation tools. The licensee's ALDC Life Enrichment Programs, Activities & Outdoor Space policy, dated August 1, 2022, indicated, "As an Assisted Living with Dementia Care licensed facility, [licensee] strives to provide valuable activities and life enrichment programs for residents living with dementia." and "2. Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:: past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, identification of activities for behavioral interventions 3. An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. 4. A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35018	A. BUILDING: _____ B. WING _____	03/29/2023

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02310	Continued From page 28 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for four of four residents (R2, R7, R8, R9) who utilized hospital bed rails or consumer grab bars. This resulted in issuance of an immediate correction order on March 28, 2023, at 12:43 p.m. Further, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping for two of two residents (R3, R10) reviewed for O2 storage. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: SIDE RAILS: R2 R2 had diagnoses to include Alzheimer's disease. R2's service plan dated August 1, 2021, indicated services included assistance with bathing, grooming, toileting, feeding, transfers, medication administration and blood glucose testing.	02310		

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	35018	A. BUILDING: _____ B. WING _____	03/29/2023

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02310	Continued From page 29 On March 28, 2023, at 8:30 a.m. a hospital style 1/2 upper side rail was observed to be affixed on the right side of the bed and in the upright position. R7 R7 had diagnoses to include memory loss. R7's signed service plan dated August 11, 2021, indicated services included assistance with activities of daily living (ADLs) bathing, toileting, transfers, laundry, housekeeping and medication administration. On March 28, 2023, at 12:28 p.m. a hospital style 1/2 upper side rail was observed to be affixed on the left side of the bed and in the downward position. R8 R8 had diagnoses to include cognitive impairment. R8's service plan dated September 21, 2022, indicated services included ADLs, toileting, laundry, housekeeping, and medication administration. On March 28, 2023, at 12:30 p.m. R8's hospital style 1/2 upper bilateral side rails were observed in upright position. R9 R9 had diagnoses to include type two diabetes, generalized anxiety order and dementia. R9's service plan dated July 8, 2021, indicated services included ADLs, bathing, housekeeping, laundry, and medication administration. On March 28, 2023, at 12:30 p.m. an observation of R9's hospital bed included a hospital style 1/2 upper side rail was observed to be affixed on the right side of the bed and in the upright position.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 30 R2, R7, R8, and R9's records included a siderail assessment dated January 5, 2023, July 21, 2022, October 12, 2022, and July 9, 2021, respectively. The assessment lacked documentation of specific measurements within the Food and Drug Administration (FDA) guidelines for zones one through four. On March 28, 2023, at 12:20 p.m. director of nursing (DON)-B stated the hospital side rails were not measured. DON-B acknowledged that all four residents' side rail assessments did not include specific measurements for the hospital style bed rails. DON-B indicated there were nine residents total in the facility that had the hospital style side rails, and confirmed none of the siderails had been measured. The licensee's policy dated July 1, 2014, indicated "[licensee] limits the use of medical devices to those that are considered "safe" based on current standards of practice. When [licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] shall assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails. In addition, [licensee] will verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. [licensee] policy regarding side rails includes a signed waiver by the resident that they have been informed of the potential benefits and risks. This signed/dated consent will remain in the resident's permanent record. 1. Staff from [licensee] shall determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below:	02310		

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02310	Continued From page 31 a. The side rail is used consistent with manufacturer's directions. b. The side rails are installed securely and maintained in good operating condition. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75"." The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Immediate An immediate correction order was identified on March 28, 2023, at 12:43 p.m., and issued for tag identification 2310 related to side rails. On March 29, 2023, at 12:33 p.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I. OXYGEN STORAGE: R3	02310		

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02310	Continued From page 32 R3 was admitted for cares and services on November 17, 2020. R3's service plan, dated October 26, 2020, indicated R3 received services of medication administration. On March 29, 2023, at 12:00 p.m., two large oxygen cylinders and two small oxygen cylinders were observed with registered nurse (RN)-O to be unsecured with no crate available in R3's living space. R10 R10 was admitted for cares and services on May 8, 2018. R3's service plan, dated August 1, 2021, indicated R10 received services of medication administration and assistance with oxygen. On March 29, 2023, at 12:10 p.m., three small oxygen cylinders were observed with registered nurse (RN)-O to be stored unsecured next to a crate which held 13 thirteen small, secured cylinders in R10's living room. On March 29, 2023, at 12:15 p.m., RN-0 indicated she was unaware oxygen cylinders needed to be stored in a crate. On March 29, 2023, at 12:30 p.m., licensed assisted living director (LALD)-A and DON-B confirmed they were unaware of the unsecured oxygen cylinders. On March 30, 2023, at 8:45 a.m., a representative from R3's oxygen supply company stated they only send a cylinder crate if there are more than 2 cylinders being ordered and would	02310		

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02310	Continued From page 33 follow the facility's storage policy. The licensee's Oxygen policy dated August 1, 2021, indicated oxygen cylinders must remain upright at all times, but did not address how to store oxygen cylinders. R10's oxygen supply company's undated document, Safe Oxygen Cylinder Storage, indicated "Do not store oxygen cylinders in a freestanding upright position." The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16,2020, stated, "Cylinders must be secured (chains or racks) to prevent them from falling over." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *03/27/23*
Time: 15:05:39
Report: 1036231062

Food and Beverage Establishment Inspection Report

Location:
Heritage Of Edina Inc
3456 Heritage Drive
Edina, MN55435
Hennepin County, 27

Establishment Info:
ID #: 0039032
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529209145
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO HIGH TEMPERATURE INDICATOR DEVICE FOR MEASURING SURFACE TEMPERATURE OF HIGH TEMP DISH MACHINE. PROVIDE AND MAINTAIN.

Comply By: 04/03/23

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.

KITCHEN HAD EXPIRED QUAT TEST STRIPS FOR MEASURING CONCENTRATION OF SANITIZING SOLUTION. PROVIDE AND MAINTAIN AN APPROPRIATE TEST KIT.

Comply By: 04/03/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED SIGNIFICANT FOOD RESIDUE BUILD UP ON CAN OPENER. ISSUE CORRECTED ON SITE.

Comply By: 03/27/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

OBSERVED SEVERAL AREAS THROUGHOUT THE KITCHEN WHERE THE TILES WERE DAMAGED AND THE GROUT WAS DETERIORATING. COMPLY WITH ABOVE RULE.

Comply By: 06/28/23

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

OBSERVED SEVERAL LIGHT BULB SHIELDS THROUGHOUT THE KITCHEN THAT ARE DAMAGED/CRACKED. COMPLY WITH ABOVE RULE.

Comply By: 05/08/23

Surface and Equipment Sanitizers

QUATERNARY AMMONIA: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY
Violation Issued: No

UTENSIL SURFACE TEMP: = at 163.3 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: VULCAN DOUBLE DOOR REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 41 Degrees Fahrenheit - Location: KENMORE FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: FRIDGIDAIRE FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -6 Degrees Fahrenheit - Location: AURORA DOUBLE DOOR REACH IN
Violation Issued: No

Type: Full
Date: *03/27/23*
Time: 15:05:39
Report: 1036231062
Heritage Of Edina Inc

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYORS FROM HRD WAS JOLENE BERTELSEN AND TAMMY CARLSON. INSPECTION CONDUCTED IN PRESENCE OF PREETHA KURIAN, THE KITCHEN MANAGER. ALL VIOLATIONS WERE DISCUSSED WITH KITCHEN MANAGER AND HRD EVALUATORS DURING INSPECTION.

MAJORITY OF FOOD IS PREPARED NEXT DOOR AT THE REMBRANDT BUILDING AND BROUGHT OVER TO THE TIFFANY BUILDING FOR SERVING APPROXIMATELY 48 RESIDENTS. FOOD IS PREPARED FOR SAME DAY SERVICE AND LEFTOVERS ARE NOT SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH KITCHEN MANAGER:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036231062 of 03/27/23.

Certified Food Protection Manager: PREETHA KURIAN

Certification Number: fm10010 Expires: 06/15/23

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

PREETHA KURIAN
KITCHEN MANAGER

Jeff Johanson