DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 28, 2023

Licensee
Silver Maple Residence, Inc.
802 28th Street Southeast
Brainerd, MN 56401

RE: Project Number(s) SL30711016

Dear Licensee:

On June 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 12, 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,

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

PMB

Electronically Delivered

May 1, 2023

Licensee
Silver Maple Residence, Inc.
802 28th Street Southeast
Brainerd, MN 56401

RE: Project Number(s) SL30711016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000.00

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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 MDH 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

(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: SL30711016 On April 10, 2023, through April 12, 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 12 active residents receiving services under the 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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. 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 April 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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	0 485		

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0 485	Continued From page 2 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals were served daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. This had the potential to affect all current 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: During entrance conference on April 10, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A stated the menus were posted in the	0 485		

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0 485	Continued From page 3 kitchen areas. During the facility tour on April 10, 2023, at 11:30 a.m., the surveyor observed the posted menu in the kitchen in building 814. The menu included lunch and supper, but no breakfast. Unlicensed personnel (ULP)-E stated the residents could have whatever kind of breakfast they want. On April 10, 2023, at 3:05 p.m., surveyor reviewed menus with LALD-A. LALD-A stated all cooking for lunch and supper were completed at a nearby facility and food was brought to the 802 and 814 buildings. Menus reviewed were incomplete: lacking breakfast offerings, descriptions of sides, description of main meals, types of juice and did not offer fresh fruits and vegetables daily. LALD-A stated the menus were in complete. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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	0 580		

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0 580	Continued From page 4 must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided. This had the potential to affect all 12 residents receiving assisted living services. 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: During the entrance conference on April 10, 2022, at 10:45 a.m., licensed assisted living director (LALD)-A stated she would need to ask clinical nurse supervisor (CNS)-C for quality management activity notes. On April 12, 2023, at 9:40 a.m., LALD-A stated she had "corporate notes" from meetings with the owners. Included in corporate notes were census, maintenance, and future meeting plans with leadership, however, lacked inclusion of quality activites specific to the licensee. The licensee's undated Quality Management policy, noted data and information that would be evaluated by the Quality Council were: -complaints and feedback from clients, clients'	0 580		

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0 580	Continued From page 5 families and representatives, and facility staff -vulnerable adult reports to the RN -incident reports -medication errors -result in client record audits -results of personnel file audits -results of MDH surveys -other relevant information for improved quality of care No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 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 6 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, interview and record review, the licensee failed to have a written emergency preparedness plan with all required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 10, 2023, at 10:45 a.m., during a facility tour with licensed practical nurse (LPN)-B, the surveyor observed the licensee's emergency plan book posted prominently. The licensee's emergency preparedness plan dated July 1, 2022, lacked the following content and/or policies and procedures to address: - a comprehensive program to include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP	0 680		

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0 680	Continued From page 7 officials/organizations; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. In addition, the licensee lacked a communication plan, as part of the emergency preparedness plan, that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On April 12, 2023, at 12:13 p.m., LALD-A confirmed the documents in the licensee's emergency preparedness plan book was the facilities emergency plan information. No further information was provided.	0 680		

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0 680	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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 maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On April 10, 2023, between 11:30 a.m. and 12:35 p.m., survey staff toured the facility with the	0 800		

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0 800	Continued From page 9 licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following in the 802 building: 1. The crank mechanisms were not working properly on both egress windows in a resident's sleeping room, which prevented these windows from opening fully. Egress windows that do not function properly would prevent a safe and quick exit in the event of an emergency. 2. One electrical wall outlet in a vacant resident room was not provided with a cover. Electrical outlets that are not properly covered could expose residents to electrical wiring. 3. The switch for the exhaust fan was broken, making it difficult to operate, in a common-use resident bathroom. These deficient conditions were visually verified by LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) 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 emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 10 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 record review and interview, the licensee failed to provide accurate evacuation plans and documentation to support that the training frequency on fire safety and evacuation for employees and residents was met. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 Findings include: On April 10, 2023, between 11:30 a.m. and 12:35 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that in building 814, the evacuation plans posted labeled a room as a kitchenette, when this room was being used as an office. This deficient condition was visually verified by LALD-A accompanying on the facility tour. On April 10, 2023, at approximately 12:35 p.m., records were provided for review. Records were reviewed by survey staff on April 10, 2023, between 12:35 p.m. and 1:20 p.m. Documentation was requested by survey staff but not provided to support that annual resident training had been completed for residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. On April 10, 2023, at approximately 1:35 p.m., during an interview, the licensed assisted living director (LALD)-A verified that documentation was not available to support that annual resident training had been completed. Documentation was provided for an employee in-service training that had been completed within the last year on fire safety and evacuation. On April 10, 2023, at approximately 1:35 p.m., during an interview, the LALD-A explained that employee training for the fire safety and evacuation plans was completed upon hire and then annually but did not require training at least twice per year after hire. On April 10, 2023, at approximately 1:35 p.m., the LALD-A verified this deficient condition.	0 810		

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	30711	A. BUILDING: _____ B. WING _____	04/12/2023

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0 810	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	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 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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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).	0 820		

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0 820	Continued From page 13 Findings include: On April 10, 2023, between 11:30 a.m. and 12:35 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed key-only locks installed on the front doors that had exit signs posted over them in the 802 and 814 buildings. Additionally, the back doors of buildings 802 and 814 were shown on the evacuation plans as exits, and key-only locks were installed on these doors. The office (labeled as a kitchenette on the plans) in building 814 was shown as an exit on the evacuation plans and a key-only lock was installed on this door. In the event of an evacuation, exit doors with key-only locks could delay a safe and quick exit. These deficient conditions were verified by LALD-A accompanying on the facility tour. 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	0 900		

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0 900	Continued From page 14 (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. (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 observation and interview, the licensee failed to execute a written contract with the required content for renters occupying the one bedroom second-floor apartment in building 802 and 814. This had the potential to affect all 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 an 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 or in several	0 900		

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0 900	Continued From page 15 locations but is not found to be pervasive). The findings include: On April 10, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated each address (802 and 814) had a one-bedroom apartment on the second floor. LALD-A stated the new owners occupy the 802 apartment approximately five days out of the month, and the 814 apartment was rented by an employee. LALD-A stated written leases were used for these apartments, and she was not aware these apartments are considered as part of the assisted living. Neither of these occupants had an asssited living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=C	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	0 950		

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0 950	Continued From page 16 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 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 include in the assisted living contract the required verbiage to designate a representative for two of two residents (R2, R5). This had the potential to affect all twelve residents. This practice resulted in a level one violation (a violation that has no potential to cause more than minimal impact on the resident and does not affect the health and 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: R2 R2's diagnoses included diabetes (low blood sugar), back pain, and hypertension (high blood	0 950		

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0 950	Continued From page 17 pressure). R2's service plan dated January 9, 2023, indicated R2 received assistance with ambulating, transferring, housekeeping, laundry, and medications assistance. R2's assisted living contract dated January 9, 2023, did not contain the language required as written in the statute regarding the resident's right to designate a representative. R5 R5's diagnoses included diabetes (low blood sugar), back pain, and schizophrenia (a mental illness that affects how a person thinks, feels, and behaves). R5's service plan dated September 15, 2022, indicated R5 received assistance with ambulating, transferring, bathing, grooming, housekeeping, laundry, and medications assistance. R2's assisted living contract dated January 9, 2023, did not contain the language required as written in the statute regarding the resident's right to designate a representative. On April 10, 2023, at 3:05 p.m., licensed assisted living director (LALD)-A stated all residents received the same assisted living contract, and was not aware the designated representative verbiage was incorrect. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations were provided for one of three employees (clinical nurse supervisor (CNS)-C). This had the potential to affect all 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 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: CNS-C was hired on May 1, 2000, and began providing services under the assisted living license on August 1, 2021. CNS-C's employee records did not provide documentation to indicate the assisted living	01460		

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01460	Continued From page 19 facility training was completed. On April 12, 2023, at 12:42 p.m., CNS-C stated she wasn't sure if she had any of the required orientation for assisted living licensure. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated March 1, 2023, indicated all assisted living employees must complete an orientation to assisted living facility requirement before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 20 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01500		

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01500	Continued From page 21	01500		

review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each twelve (12) months of employment for one of three employees (clinical nurse supervisor (CNS)-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:

CNS-C was hired on May 1, 2000, and began providing services under the assisted living license on August 1, 2021.

CNS-C's employee training records lacked annual training for 2021 or 2022 to include:
-training on reporting of maltreatment of vulnerable adults under section 626.557;
-review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
-review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
-effective approaches to use to problem solve

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01500	Continued From page 22 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 12, 2023, at 12:42 p.m., CNS-C stated she had no documentation she completed annual training, and was not sure what she had done. The licensee's Annual In-Service Training policy dated August 1, 2017, indicated all staff that performs direct home care services, including licensed staff, must complete at least 8 hours of annual training for each 12 months of service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 23 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for three of three residents (R2, R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 R2's diagnoses included diabetes (low blood sugar), back pain, and hypertension (high blood	01620		

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01620	Continued From page 24	01620		

pressure).

R2's service plan dated January 9, 2023, indicated R2 received assistance with ambulating, transfers, bathing, housekeeping, laundry, and medications assistance.

R2's record included Monitoring Visit Notes, dated December 22, 2022, and March 22, 2023. These assessments indicated all home care services were being performed adequately, the care plan/service plan was reviewed, services appropriate to the resident's needs, and resident states satisfaction with staff and services, and no new needs noted.

R3
R3's diagnoses included schizoaffective disorder depressive type, alcohol use disorder, degenerative disc disease (cushioning in the spine wears away).

R3's service plan dated July 1, 2022, indicated R3 received assistance with ambulation, transfers, bathing, housekeeping, laundry and medication assistance.

R3'S record included Monitoring Visit Notes, dated December 22, 2022, and March 22, 2023. These assessments indicated all home care services were being performed adequately, the care plan/service plan was reviewed, services appropriate to the resident's needs, and resident states satisfaction with staff and services, and no new needs noted.

R5
R5's diagnoses included diabetes (low blood sugar), back pain, and schizophrenia (a mental illness that affects how a person thinks, feels, and

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SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

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01620	Continued From page 25 behaves). R5's service plan dated September 15, 2022, indicated R5 received assistance with ambulating, transfers, bathing, grooming, housekeeping, laundry, and medications assistance. R5's record included Monitoring Visit Notes, dated December 22, 2022, and March 22, 2023. These assessments indicated all home care services were being performed adequately, the care plan/service plan was reviewed, services appropriate to the resident's needs, and resident states satisfaction with staff and services, and no new needs noted. On April 12, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-C stated the 90-day assessments evaluated the resident's current service plan to ensure the facility was meeting the needs of the resident. She confirmed the Monitoring Visit Notes was the 90-day assessments used for all residents and did not include all content required for the uniform assessment tool in Minnesota Rules Chapter 4659.0150, Subp. 2. The licensee's Monitoring of Clients and Their Services policy dated August 1, 2017, indicated the RN will identify any problems or client's concerns, evaluate the effectiveness of the services, medications, and treatments, and identify any change in condition or new symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

(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
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were stored in a secured location for all residents in building 802 and failed to ensure medications for one of three residents were stored according to the manufacturer's recommended temperature. 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: MEDICATION STORAGE On April 10, 2023, at 12:05 a.m., surveyor observed in building 802, two (2) black four (4) drawer filing cabinets used for medication storage. Neither medication storage filing cabinets were locked. Licensed practical nurse (LPN)-B stated both cabinets should be locked. Unlicensed personnel (ULP)-D stated she was not taught to lock the file cabinets. On April 10, 2023, at 12:24 p.m., surveyor	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

(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
01880	Continued From page 27 observed another unlocked two (2) drawer tan file cabinet containing three (3) bottles of Haloperidol Lactate 2 milligram (mg) solution, one (1) 120 ml partially full bottle and two (2) full 15 ml bottles with other oral medications belonging to resident (R6). LPN-B immediately removed liquid and oral medications and placed them in black file cabinet and stated to the unlicensed personnel ULP's, medication should not be stored in the tan file cabinet which cannot be locked. On April 12, 2023, at 12:42 p.m., clinical nurse supervisor (CNS)-C stated her expectation was the file cabinets used for medication storage should be locked unless ULPs were administering medications. MEDICATION REFRIGERATOR TEMPERATURES On April 10, 2023, at 12:10 p.m., surveyor observed a locked medication refrigerator located under the ULP desk in building 802. LPN-B unlocked and confirmed temperature was 78 degrees Fahrenheit (F) and stated it must have stopped working. LPN-B removed the following medications stored in the refrigerator: -four unopened Basaglar Kwik pens 100 unit/milliliter(ml) for R5 LPN-B confirmed the last documented temperature on the temperature log was 38 degrees F on April 9, 2023, on evening shift. The manufacturer's instructions for Basaglar insulin pens dated July 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). On April 12, 2023, at 12:42 p.m., CNS-C stated the medication refrigerator was working again.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

(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
01880	Continued From page 28 The licensee's Storage of Medication policy dated August 1, 2017 noted the registered nurse (RN) may identify the need for secured storage of the medications within the client's private living space (or in a central storage area in a senior housing setting) because of the client's status, concerns about medication diversion or other concerns, when secured storage of the medication is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time-sensitive medications with an open and expiration date for one of two residents (R2), failed to monitor for expired medications for one of two residents (R4), and monitor for expired over the counter (OTC) stock medications.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

(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
01890	Continued From page 29	01890		

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:

TIME SENSITIVE MEDICATIONS
On April 10, 2023, at 11:46 a.m., a tour and a review of locked medication storage was conducted in the licensee's two buildings (802 and 814) with licensed practical nurse (LPN)-B. The following was observed and confirmed with LPN-B:

R2's Victoza 18 milligram (mg)/3 milliliter (ml) and Lantus 100 units/ml insulin pens (multiple dose pen shaped injector device for insulin administration) lacked opened and expiration dates.

EXPIRED MEDICATIONS

R4's MiraLAX 17-gram powder administered daily and as needed had expired November 2022.

OTC STOCK MEDICATIONS
One (1) full, and 1 partial Geri-Lanta antacid 12-ounce bottles with expiration dates of November 2022, were found in the OTC storage cupboard used by residents as needed.

The manufacturer's instructions Victoza insulin pens dated June 2022, directed to discard the pen 30 days after it had been opened, even if it still had insulin left in it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30711	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	802 28TH STREET SE BRAINERD, MN 56401

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01890	Continued From page 30 The manufacturer's instructions for Lantus insulin pens dated June 2022, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Storage of Medications policy, dated August 1, 2017, indicated the registered nurse (RN) would establish a system that addressed storage and handling of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *04/10/23*
Time: 11:30:00
Report: 1017231084

Food and Beverage Establishment Inspection Report

Location:
Silver Maple Residence Inc
802 28th Street SE
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0041244
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #: 2188398146
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.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ** Priority 1 **

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

SOUP LOCATED IN PAN ON STOVE TOP WAS MEASURED AT 129 DEGREES F. MAINTAIN AT 135 MINIMUM TEMP. DISCUSSED TIME VS. TEMP AS AN OPTION FOR MICROBIAL CONTROL.

Comply By: 04/10/23

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COTTAGE CHEESE LOCATED IN UPRIGHT COOLER 814 28TH STREET HOUSE MEASURED 46 DEGREES F. MAINTAIN COLD FOOD AT 41 DEGREE MAXIMUM TEMPERATURE.

Comply By: 04/10/23

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

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

BOTH DISH MACHINES LOCATED AT 802 AND 814 28TH STREET SE MEASURED 150 DEGREES F. MAINTAIN AT 160 MINIMUM TEMP.

Comply By: 04/10/23

2-100 Supervision

2-101.11 ** Priority 2 **

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

WIPING CLOTH BUCKET LOCATED IN 802 HOUSE MEASURED 0 PPM CHLORINE SOLUTION. MAINTAIN CHLORINE SOLUTION AT 50 PPM MINIMUM CONCENTRATION.

Comply By: 04/10/23

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

SAUSAGE LOCATED IN 814 28TH STREET SE HOUSE WAS NOT DATE MARKED. MARK DATE OF PREP ON ALL FOOD LOCATED IN FRIDGE.

Comply By: 04/10/23

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.

CHLORINE SANITIZER IS BEING USED FOR SANITIZING SOLUTION IN WIPING CLOTH BUCKET . PROVIDE CHLORINE TEST STRIPS TO MEASURE CONCENTRATION OF SANITIZER.

Comply By: 04/17/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CFPM IS BEING USED AT BOTH LICENSED SILVER MAPLE ESTABLISHMENTS 710 AND 802. MITCHELLS CERTIFICATE CAN ONLY BE USED AT ONE ESTABLISHMENT. EMPLOY CFPM AT BOTH LOCATIONS.

Comply By: 04/10/23

Surface and Equipment Sanitizers

Hot Water: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Hot Water: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Chlorine: = at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: CHEESE LOCATED IN UPRIGHT COOLER 802 HOUSE

Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: COTTAGE CHEESE LOCATED IN UPRIGHT COOLER 802 HOUSE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 129 Degrees Fahrenheit - Location: CHICKEN ALFREDO LOCATED IN PAN ON STOVE TOP
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: COTTAGE CHEESE LOCATED IN COOLER AT 814 HOUSE
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: PASTACIO PUDDING LOCATED IN UPRIGHT COOLER 802 HOUSE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK LOCATED IN 2ND COOLER 814 HOUSE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SAUSAGE LOCATED IN 2ND COOLER 802 HOUSE
Violation Issued: No

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

DISCUSSION:

THIS LICENSE AND INSPECTION IS FOR TWO ESTABLISHMENTS 802 28TH STREET SE AND 814 28TH STREET SE.

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

Food and Beverage Establishment Inspection Report

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 1017231084 of 04/10/23.

Certified Food Protection Manager: MITCHELL E. KARELS

Certification Number: FM 96199 Expires: 05/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231084

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	6	**Date**	04/10/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	City/State	Zip Code	Telephone
Silver Maple Residence Inc	802 28th Street SE	Brainerd, MN	56401	2188398146

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0041244		Full		

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 Hygenic 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 pprocedure 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 proceedures 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

			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 labled; 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		

			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		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:** 04/14/23

Inspector (Signature)