DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 24, 2023

Licensee
Silvercreek On Main
8200 Main Street
Maple Grove, MN 55369

RE: Project Number(s) SL31620015

Dear Licensee:

On February 8, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 16, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Electronically Delivered

January 9, 2023

Licensee
SilverCreek On Main
8200 Main Street
Maple Grove, MN 55369

RE: Project Number(s) SL31620015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31620015-0 On December 12, 2022, through December 13, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 299 residents: 69 receiving services under the Assisted Living with Dementia Care. On December 13, 2022, an immediate order was issued for 1290. The immediacy was removed on December 14, 2022.	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	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. 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 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated December 13, 2022.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 3 The findings include: CARES On December 13, 2022, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-E wash the axillary area and then wash eyes of R8. On December 13, 2022, at 7:31 a.m. to 7:57 a.m., the surveyor observed ULP-E provide peri-care to R12. ULP-E used a washcloth to clean peri area and wiped from front to back as well as back to front and used the same area of the washcloth for each wipe. ULP-E completed peri-care dressing, grooming, and transfer without performing hand hygiene after multiple glove removals. In addition, the surveyor observed ULP-C assist with grooming, dressing, bedmaking, and transfer, and did not perform hand hygiene after glove removals. On December 13, 2022, at 8:05 a.m. to 8:25 a.m., the surveyor observed ULP-E provide peri-care to R10. ULP-E used wipes to clean peri-area and wiped from front to back as well as back to front and used the same area of the wipe. ULP-E double gloved during peri-care and removed one set of gloves after bowel movement was removed from R10. ULP-E completed peri-care dressing, grooming, bedmaking and transfer without performing hand hygiene after multiple glove removals. In addition, the surveyor observed ULP-C assist with application of lotion to legs, grooming, dressing, and transfer, and did not perform hand hygiene after glove removals. On December 13, 2022, at 8:27 a.m., ULP-E stated hand hygiene should be performed before and after gloves, and between cares. In addition, ULP-E stated when providing peri-care you should wipe front to back to prevent infection or	0 510		

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0 510	Continued From page 4 skin breakdown. On December 13, 2022, at approximately 8:33 a.m., the surveyor observed ULP-H remove soiled incontinence product and placed on the floor, then proceeded to provide peri-care on R2, after peri-care ULP-H placed the incontinence product in the garbage can. On December 13, 2022, at approximately 8:55 a.m., ULP-H stated it is expected that soiled incontinence product would be placed in a garbage can and that they would have followed this protocol if there had been a bag in the receptacle. On December 13, at 10:22 a.m., the surveyor observed ULP-B administer R2's eye drops to R11 before performing hand hygiene or wearing gloves. On December 13, 2022, at 10:23 a.m., registered nurse (RN)-A stated hand hygiene should occur before and after glove removal, if hands are soiled, and between resident cares. In addition, RN-A stated residents should be wiped from front to back when peri-care is performed. MEDICATION PASS On December 13, 2022, at 8:35 a.m., the surveyor observed ULP-B administer medications to R11 before washing or sanitizing hands. On December 13, 2022, at 8:38 a.m., ULP-C stated sanitizer was kept on the top of the cart and went "missing" this morning. The surveyor observed ULP-C continue with medication pass and did not perform hand hygiene between R9 and R12.	0 510		

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0 510	Continued From page 5 On December 13, 2022, at 10:27 a.m., RN-A stated when medication was passed, staff were expected to perform hand hygiene between residents. DROPPED MEDICATION On December 13, 2022, at 7:40 a.m., during medication administration, the surveyor observed ULP-B drop R11's medication on the medication cart, picked up the medication with ungloved hands, put medication back into the medication cup, and administer all medications to R11. On December 13, 2022, at 10:20 a.m., during medication administration, the surveyor observed ULP-B drop R16's medication on the medication cart, picked up medication with ungloved hands, put medication back into the medication cup, and administer all medications to R16. On December 13, 2022, at 10:38 a.m., RN-A stated the top of medication cart was disinfected however, if medication was dropped, the protocol should be followed to dispose and request for new medication. The licensee's Infection Control policy dated August 1, 2021, indicated infection control practices are important to licensee. The policy also indicated proper hand washing techniques should be used to protect the spread of infection, and gloves must be worn whenever there may be direct contact between employee and contaminated objects. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings dated July 28, 2022, indicated practicing hand hygiene is a simple yet effective way to prevent infections in healthcare settings.	0 510		

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0 510	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all 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 of the residents). The findings include: On December 12, 2022, at approximately 11:30	0 970		

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0 970	Continued From page 7 a.m., licensed assisted living director (LALD)-D provided the surveyor with a blank Assisted Living Contract: Terms & Conditions and indicated the contract was used by licensee for all residents who received services. The contract included the following three sections: - Liability which read, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless form any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on the Provider's premises."; - Personal Property which read, "Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence."; and -Indemnification which read, "Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents."	0 970		

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0 970	Continued From page 8 On December 12, 2022, at 11:30 a.m., LALD-D stated the licensee became aware of the requirement listed above last week and provided the surveyor with a draft of the revised sections listed above the licensee intends to send out to all residents after their lawyers approve the revision of the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 9 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure a notice with required content was provided to the resident/representative for two of two residents (R2, R4) who had an emergency relocation out of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee for services on October 11, 2019.	01060		

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01060	Continued From page 10 R2's Individual Service Plan dated November 24, 2021, indicated R2 received medication set up and administration, dressing and grooming, assistance with meals, reassurance checks, housekeeping, assistance with transfers, and laundry services. R2's nursing progress note dated October 19, 2022, indicated that R2 had an emergency relocation via ambulance to the hospital following right hip pain that worsened with movement. R2 returned to the licensee on October 31, 2022, after staying in the hospital for 13 days. R4 R4 was admitted to the licensee for services on July 22, 2022. R4's Individual Service Plan dated July 22, 2022, indicated R4 received medication set up and administration, dressing and grooming, assist with meals, reassurance checks, housekeeping, and laundry services. R4's Evaluation and Management notes received via fax indicated R4 had a hospitalization from September 8, 2022, through September 11, 2022, for increased weakness and frequent falls. R2 and R4's records included a Cover Sheet for Notices from Assisted Living Facilities to the Office of Ombudsman for Long-Term Care (OOLTC) dated October 24, 2022, and September 12, 2022, indicating the type of notice as Notice of Emergency Relocation with a check mark. R2 and R4's record also included undated notice to all residents and families indicating the licensee is required to inform resident in the event of an emergency relocation then pasted the	01060		

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01060	Continued From page 11 statute language. Although R2 and R4 were relocated from the facility for 13 days (October 19 through October 31), and 4 days (September 8 through September 11) R2 and R4's records lacked evidence the licensee provided the residents or representative written emergency relocation notice as required. On December 13, 2022, at 2:40 p.m., licensed assisted living director (LALD)-D stated the information provided was what the licensee provided to the residents and their representatives and the ombudsman in case of emergency relocation. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of three employees (unlicensed personnel (ULP)-B). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 13, 2022, from 7:28 a.m. to 10:20 a.m., the surveyor observed ULP-B administer medications to first floor memory care residents. ULP-B started work at the licensee's facility on September 23, 2016, under the comprehensive home care license and started providing assisted living services on August 1, 2021. ULP-B's employee record included background study clearance letter dated September 15, 2016. On December 13, 2022, at 1:33 p.m., the NetStudy 2.0 website indicated ULP-B had a background study completed with different licensee however, no background study was completed for or affiliated with the current licensee. On December 13, 2022, at 1:40 p.m., licensed assisted living director (LALD)-D stated ULP-B's	01290		

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01290	Continued From page 13 background study could not affiliate to the licensee's health facility identification number (HFID). LALD-D also stated on an unspecified date, the licensee scheduled ULP-B for finger printing, but ULP-B did not go to the appointment. On December 13, 2022, at 3:10 p.m., LALD-D stated in 2021, the licensee hired a company to complete background studies for all the licensee's employees. LALD-D stated any employees who were unable to attend that time were given a code to complete finger printing independently. The surveyor inquired how they ensured the background studies were completed for the employees who fingerprinted independently. LALD-D stated HR tracked when employees' background studies were completed. The Licensee's Background Studies policy dated August 1, 2021, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors at each licensed assisted living community. The policy also indicated no employee will provide direct services and have contact with residents until acceptable results have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 14, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	01290		

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01500	Continued From page 14	01500		
01500 SS=E	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 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	01500		

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01500	Continued From page 15 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 review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for three of four employees (unlicensed personnel (ULP)-B, ULP-C, registered nurse (RN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01500		

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01500	Continued From page 16 The findings include: ULP-B ULP-B had a hire date of September 23, 2016, under the comprehensive home care license and started providing assisted living services on August 1, 2021. On December 13, 2022, from 7:28 a.m. to 10:20 a.m., the surveyor observed ULP-B administer medications to first floor memory care residents. ULP-B's employee record lacked documentation of eight hours of annual training completed within the last year, including the following required topics: - Reporting maltreatment of vulnerable adults or minors; - Infection control techniques; and - Review of provider 's policies and procedures. ULP-C ULP-F had a hire date of May 2, 2017, under the comprehensive home care license and started providing assisted living services on August 1, 2021. On December 13, 2022, at approximately 7:15 a.m., the surveyor observed ULP-C transfer R8 into wheelchair. ULP-C's employee record lacked documentation of eight hours of annual training completed within the last year, including the following required topics: - Reporting maltreatment of vulnerable adults or minors; and - Infection control techniques. RN-F	01500		

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01500	Continued From page 17 RN-F had a hire date of July 13, 2021, under the comprehensive home care license and started providing assisted living services on August 1, 2021. On December 13, 2022, at 8:43 a.m., the surveyor observed RN-F assist with an investigation for a narcotic count. RN-F's employee record lacked documentation of eight hours of annual training completed within the last year, including the following required topics: -assisted living bill of rights; and -infection control techniques. On December 13, 2022, at 1:16 p.m., licensed assisted living director (LALD)-D stated all employees should receive at least eight hours of annual training. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff providing direct care will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01760 SS=F	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	01760		

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01760	Continued From page 18	01760		

administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were administered per providers' orders for three of five residents (R3, R9, R12).

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:

R9
R9's Individualized Service Plan signed August 11, 2022, indicated R9 received assistance with dressing, bathing, housekeeping, laundry, medication administration, safety checks, meals, and nurse visits.

R9's provider orders dated September 9. 2022, included Advair HFA 45 micrograms (mcg) / 21 mcg inhaler inhale 2 puffs twice per day and

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01760	Continued From page 19 albuterol sulfate HFA 90 mcg inhaler administer 2 puffs every four hours as needed. On December 13, 2022, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-C document on the electronic medication administration record (EMAR) for Advair HFA 45 mcg/ 21 mcg inhaler and removed an albuterol 90 mcg inhaler. ULP-C proceeded to walk to the dining table to administer albuterol sulfate 90 mcg inhaler to R9. The surveyor intervened to stop medication administration of albuterol sulfate 90 mcg inhaler on R9. On December 13, 2022, at 8:38 a.m., ULP-C stated they believed it was the correct medication because it was the only inhaler in the medication cart for the resident at the time of administration. R12 R12's Individualized Service Plan signed February 3, 2022, indicated R12 received assistance with dressing, mobility, grooming, toileting, bathing, transfers, meals, safety checks, medication administration, laundry, housekeeping, and nurse visits. R12's provider orders dated September 5, 2022, included diclofenac sodium 1 percent (%) gel apply topically to the left knee twice per day. On December 13, 2022, at 8:43 a.m., the surveyor observed ULP-C place an unmeasured amount of diclofenac gel 1 % to the fingertips and applied the gel to the left knee of R12. On December 13, 2022, at 9:14 a.m., registered nurse (RN)-F stated staff applied diclofenac gel to their fingertips and apply the gel to the location on the order. In addition, RN-F stated the	01760		

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01760	Continued From page 20	01760		

prescription did not list a dosage to apply and the pharmacy should have noticed the error and alerted the staff.

R3
R3's Individualized Service plan signed January 7, 2022, indicated R3 received assistance with dressing, grooming, toileting, bathing, housekeeping, laundry, medication administration, safety checks, meals, and nurse visits.

R3's provider order dated November 30, 2022, included diclofenac sodium 1 % gel apply 2 grams (g) to the left shoulder and 2 g to the lower back three times per day.

R3's EMAR dated December 1, 2022, through December 31, 2022, included diclofenac sodium 1 % gel apply 2 grams topically to the lower left back twice daily. The EMAR had scheduled diclofenac gel 1% three times throughout the day however, the order lacked application to the left shoulder.

On December 13, 2022, at 9:22, the surveyor observed ULP-C place an unmeasured amount of diclofenac gel 1 % to the fingertips and applied the gel to the lower left back of R3.

On December 13, 2022, at 10:27 a.m., RN-A stated staff were expected to use the five rights when medication is administered. In addition, RN-A stated they were unaware there was a stick in the box to measure diclofenac gel and they would train employees on application of the gel.

The licensee's Medication & Treatments - Documentation & Refusal policy dated August 1, 2021, indicated the licensee would create and

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01760	Continued From page 21 maintain a correct and accurate medication and / or treatment / therapy record for each resident receiving medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a current written or electronically recorded prescription for all prescribed medications that the assisted facility was managing for the resident for one of five residents (R12). 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: R12's Individualized Service Plan signed	01820		

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01820	Continued From page 22 February 3, 2022, indicated R12 received assistance with dressing, mobility, grooming, toileting, bathing, transfers, meals, safety checks, medication administration, laundry, housekeeping, and nurse visits. R12's provider orders dated September 5, 2022, included diclofenac sodium 1 percent (%) gel apply topically to the left knee twice per day. The provider order lacked a dosage to be administered to R12. On December 13, 2022, at 8:43 a.m., the surveyor observed ULP-C place an unmeasured amount of diclofenac gel 1 % to the fingertips and applied the gel to the left knee of R12. On December 13, 2022, at 9:14 a.m., registered nurse (RN)-F stated they were unaware diclofenac 1 % gel required a specific amount of medication to be listed and applied. In addition, RN-F stated should have noticed the error and alerted the staff. The manufactures instructions for Diclofenac (Topical Application Route) dated December 1, 2022, indicated diclofenac gel 1% should not exceed 32 g daily. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated the RN would create and maintain a correct and accurate medication and / or treatment / therapy record for each resident receiving medication administration and or therapies. In addition, the quantity dosage must be documented in the resident's medication and / or treatment / therapy records after providing the medication administration.	01820		

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01820	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 store prescription medication securely and permit only authorized personnel to have access for three of three residents (R9, R10, R12) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION REFRIGERATOR On December 13, 2022, at 7:15 a.m., the surveyor observed the second-floor nursing office propped open and unattended. The nursing office contained a medication refrigerator which lacked a locking mechanism.	01880		

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SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

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01880	Continued From page 24 On December 13, 2022, at approximately 7:26 a.m., licensed practical nurse (LPN)-G stated staff were expected to keep the nursing office door closed and locked at all times when staff were not present. In addition, LPN-G stated they were going to place a work order for a refrigerator lock to be installed immediately. On December 13, 2022, at approximately 10:15 a.m., registered nurse (RN)-A informed the surveyor a lock was installed on the medication refrigerator. RN-A stated staff were trained to shut and lock the nursing office door when staff are not present. MEDICATIONS IN RESIDENT ROOMS On December 13, 2022, at 7:31 a.m., the surveyor observed four tubes of zinc paste at the bedside of R12. On December 13, 2022, at 8:05 a.m., the surveyor observed zinc paste at the bedside of R10. On December 13, 2022, at 8:58 a.m., the surveyor observed Advair HFA 45 micrograms (mcg) / 21 mcg inhaler on the living room stand of R9. R9, R10, and R12's individualized medication management plans, indicated staff provided all medications to residents and all medications were securely stored in a locked medication cart. On December 13, 2022, at 10:36 a.m., RN-A stated all medications with the exception of self-administered medications should be kept in the locked medication cart. The surveyor inquired about creams and pastes being kept in the medication cart. RN-A stated creams were kept in	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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 25 the medication cart, then stated creams and pastes may be left at the bedside for the ULPs to apply while providing cares. The licensee's Medication Storage policy dated August 1, 2021, indicated medications managed outside of a resident's private "living space" would be securely locked and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were appropriately labeled for three of six residents (R2, R13, R14). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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 26	01890		

than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On December 13, 2022, at 9:00 a.m., the surveyor observed the second-floor memory care medication cart. The medication cart contained the follow time sensitive medications which lacked a date open label:
- latanoprost ophthalmic solution 0.005 percent (%) eye drop for R14.

On December 13, 2022, at 10:30 a.m., the surveyor observed the first-floor memory care medication cart and observed the following unlabeled medications:
- Cavilon barrier cream for R2;
- Mupirocin cream USP 2 % for R2; and
- Pain reliever (acetaminophen 500 milligram (mg)) as needed for R13. The medications did not have a pharmacy label with dispensing instructions.

On December 13, 2022, at 10:36 a.m., registered nurse (RN)-A stated all medications are labeled in the cart. RN-A stated the medication carts are audited monthly and should have noted the anomaly.

The manufacture's guidelines for Latanoprost Eye Drops dated August 8, 2022, directed eye drops to be discarded six weeks after opening.

The licensee's Medication and Treatment Orders - Receiving policy dated August 1, 2021, indicated all prescription medication must contain the name of the drug, dosage, frequency, route, indication and direction for use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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 27 No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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
02110	Continued From page 28 (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures required for assisted living facility with dementia care and ensure they were provided to each resident and/or the resident's legal and designated representative at the time of move-in. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to the dementia care were provided to each resident and/or the resident's legal and designated representative. On December 13, 2022, at 3:20 p.m., licensed assisted living director (LALD)-D indicated the licensee became aware of the requirement in the past week and were working to develop the required policies and procedures.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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
02110	Continued From page 29 The licensee's Assisted Living with Dementia Care Additional Required Policies policy dated December 6, 2021, indicated the required policies were available, and must be provided to residents and the resident's legal and designated representatives at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/13/22*
Time: 10:01:21
Report: 1024221264

Food and Beverage Establishment Inspection Report

Location:
Silvercreek On Main
8200 Main Street
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0038360
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7639551750
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW SHELLED EGGS STORED BEHIND READY TO EAT FOODS SUCH AS BOILED EGGS, CHEESE, PICKLES. ITEMS WERE REARRANGED BY STAFF ON SITE.

Corrected on Site

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.

MULTIPLE FOOD ITEMS MEASURED ABOVE 41 dF. SEE DATA CHART. ITEMS WERE STORED ON TOP OF CONTAINERS ALREADY IN THE COOLER AND/OR WERE ITEMS FILLED ABOVE THE FILL LINE. ITEMS DISCARDED ON SITE.

Corrected on Site

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OBSERVED MULTIPLE ITEMS SUCH AS TUNA SALAD AND EGG SALAD MADE ON 11/30 AND 12/2 THAT SHOULD HAVE BEEN DISCARDED AFTER 7 DAYS. DISCUSSED DAY 1 IS WHEN ITEM IS PREPARED OR OPENED AND HAS 6 ADDITIONAL DAYS FOR USE.

Corrected on Site

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.

OBSERVED MULTIPLE CONTAINERS OF TUNA SALAD, SLICED TOMATOES, DELI MEATS WITH NO DATE MARK. ITEMS WERE EITHER DISCARDED OR MARKED ON SITE BY DINING DIRECTOR.

Corrected on Site

6-400 Physical Facility Placement

6-404.11 ** Priority 2 **

MN Rule 4626.1505 Segregate products that are held for credit, redemption, or return to the distributor in a designated area that is separate from food, utensils, linens, and single-service and single-use articles.

OBSERVED MULTIPLE CANS OF FOOD WITH DENTED SEALS. CORPORATE DINING DIRECTOR SEPARATED CANS FROM DRY STORAGE AREA.

Corrected on Site

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED MULTIPLE CONTAINERS WITH WHITE SUBSTANCES WITH NO LABELS. ADVISED TO COMPLY PER ABOVE RULE.

Comply By: 12/13/22

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

OBSERVED ALL CUTTING BOARDS AND CUTTING BOARD OAT STEAM TABLE AND PREP COOLERS TO BE HEAVILY SCRATCHED AND SCORED. COMPLY PER ABOVE RULE.

Comply By: 12/13/22

5-500 Refuse and Recyclables

5-501.16C

MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.

NO WASTE RECEPTACLES OBSERVED AT DISHWASHING AREA SINK AND 3-COMP SINK AREAS. PROVIDE AND MAINTAIN. DISCUSSED PROVIDING SMALL WASTE RECEPTACLES TO PREVENT BIG RECEPTACLES FROM BEING WHEELED AROUND AND MOVED.

Food and Beverage Establishment Inspection Report

Comply By: 12/13/22

Surface and Equipment Sanitizers

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: SANI BUCKET - MAIN LINE
Violation Issued: No

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/
Temperature: 164 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Holding/CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: TOP DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/RAW BEEF
Temperature: 41 Degrees Fahrenheit - Location: BOTTOM DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/LIQUID EGG
Temperature: 36 Degrees Fahrenheit - Location: DELFIELD REACH IN COOLER
Violation Issued: No

Process/Item: Cold Holding/CUT TOMATOES
Temperature: 46 Degrees Fahrenheit - Location: DELFIELD COOLER RI #7 COOLER
Violation Issued: Yes

Process/Item: Cold Holding/LIQUID EGG
Temperature: 44 Degrees Fahrenheit - Location: DELFIELD COOLER RI #7 COOLER
Violation Issued: Yes

Process/Item: Cold Holding/SLICED TOMATO
Temperature: 36 Degrees Fahrenheit - Location: DELFIELD COOLER RI #7 COOLER
Violation Issued: No

Process/Item: Cold Holding/DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: LOWER DELFIELD RI #7 COOLER
Violation Issued: No

Process/Item: Cooling/CUT LETTUCE
Temperature: 46 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE RI #6 PREP TOP COOLER

Violation Issued: No

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE RI #6 PREP TOP COOLER

Violation Issued: No

Process/Item: Cold Holding/CARM. ONIOIN
Temperature: 49 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE RI #6 LOWER COOLER
Violation Issued: Yes

Process/Item: Cold Holding/MOZZ. CHEESE
Temperature: 45 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE RI #6 LOWER COOLER
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE RI #6 LOWER COOLER
Violation Issued: No

Process/Item: Cooling/CUT MELON
Temperature: 42 Degrees Fahrenheit - Location: SUPERIOR RI #9 STAND UP COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: SUPERIOR RI #9 STAND UP COOLER
Violation Issued: No

Process/Item: Hot Holding/PUMPKIN SOUP
Temperature: 156 Degrees Fahrenheit - Location: CAYENNE WARMER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: NORLAKE ADVANTAGE RI #1 STAND UP COOLER

Violation Issued: No

Process/Item: Hot Holding/PUMPKIN SOUP
Temperature: 165 Degrees Fahrenheit - Location: METRO C5 WARMER
Violation Issued: No

Process/Item: Hot Holding/PIZZA
Temperature: 165 Degrees Fahrenheit - Location: METRO C5 WARMER - HALLWAY
Violation Issued: No

Process/Item: Cold Holding/PASTA
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

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

DISCUSSED THE FOLLOWING ON SITE WITH DINING DIRECTOR, MELANIE HALL AND CORPORATE DINING DIRECTOR, STEVE CAMERON, AND MDH NURSING EVALUATORS ASHLEY CREWS, TESA BROWN, ROCHELLE FOX AND BENARD NYANGENA:
- BISTRO AREA HAS BEEN CLOSED SINCE COVID-19 PANDEMIC.
- ALL ORDERS ON REPORT.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY, WILL SEND NEW ILLNESS LOG WITH REPORT.
- REPORTABLE DISEASES.

- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING, AND COOLING.
- PROPER SANITIZING LEVELS.
- PEST CONTROL
- DISCUSSED KEEPING FOODS BELOW FILL LINE AND ALSO USING METAL PANS VS PLASTIC.

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 1024221264 of 12/13/22.

Certified Food Protection Manager: MELANIE L. HALL

Certification Number: FM55206 Expires: 10/09/25

Signed: _____

MELANIE HALL
DINING DIRECTOR

Signed: 

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us