Electronically Delivered

December 28, 2022

Licensee
Waverly Gardens
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number(s) SL24195015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 18, 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

The total amount you are assessed is $500. 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 Free from Maltreatment reconsideration

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

requests should be addressed to:
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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
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24195	A. BUILDING: _____ B. WING _____	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY GARDENS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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 WITH DEMENTIA CARE 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: SL24195015 On, November 14, 2022, through November 16, 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 314 residents, 90 of whom received services under the provider's Assisted Living with Dementia Care License.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on November 14, 2022, at 11:20 a.m., the surveyor observed the posted staffing plan on the wall right outside of the nursing office in an enhanced care unit that was not near the main entrance of the facility. This plan was not easily accessible to all residents, staff and visitors. On November 16, 2022, at 2:51 p.m., director of nursing (DON)-A indicated the staffing plan was only posted in the unit mentioned above and nowhere else. DON-A was unaware the staffing plan needed to be posted in a conspicuous area accessible to all residents, staff, and visitors. The licensee's MN AL Posting of Staff Schedule Policy dated August 1, 2021, directed the licensee to post a 24-hour staffing schedule that identifies staff member, shifts, days worked, hours worked, and assignments to be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 3 (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 and served according to the Minnesota Food Code. This had the potential to affect all 90 residents receiving 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated November 15, 2022, for the specific	0 480		

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0 480	Continued From page 4 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of 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 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:	0 510		

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0 510	Continued From page 5 MEDICATION REFRIGERATOR On November 15, 2022, at 8:55 a.m., the surveyor observed a 24-hour urine collection container inside a clear zip lock bag sitting on the top shelf of the medication refrigerator near medications. The surveyor asked registered nurse (RN)-Q if the container was full, and RN-Q stated yes. The surveyor observed medications inside the refrigerator were near the full urine container. On November 15, 2022, at 8:55 a.m., RN-Q was unsure why the urine container was placed in the same refrigerator as the medications. RN-Q stated, "it's my first day on my own after orientation and I don't work over here." HAND HYGIENE On November 15, 2022, at 9:45 a.m., the surveyor observed unlicensed personnel (ULP)-B set up and administer medications to R1. ULP-B proceeded to set up supplies for changing R1's overnight catheter bag to a leg bag without changing gloves or handwashing prior to procedure. ULP-B completed the task then ULP-P took the overnight bag to the bathroom to drain and clean the bag. With the same gloves from catheter care, ULP-B removed R1's soft boots and placed the boots in the closet. ULP-B applied clean socks to R1's feet. ULP-B then administered an enema (laxative) rectally to R1 and threw the supplies away, then proceeded to get the Hoyer (machine that lifts a resident) sling underneath R1 without doffing (removing) gloves or handwashing. ULP-B placed R1 on the commode. ULP-B put items into R1's dresser, made R1's bed, and handed R1 a cell phone. ULP-B then doffed dirty gloves. ULP-B put the medication box back into the closet of R1's room	0 510		

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0 510	Continued From page 6 and walked out of the room where hand washing was completed in a common bathroom. On November 15, 2022, at 10:05 a.m., the surveyor asked ULP-B if at any point gloves should have been doffed and hands washed. ULP-B indicated, "yes" and stated ULP-B was a little nervous being watched by the surveyor. On November 15, 2022, at 10:57 a.m., director of nursing (DON)-A indicated it was expected hands to be washed prior to any procedure and gloves should be changed after any procedure. DON-A also indicated all ULPs have been trained to do so. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance in Health Care Settings last reviewed January 30, 2020, directed health care workers to use an alcohol-based hand rub or wash with soap and water immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient and immediately after glove removal. The licensee's Infection Control Standard Precautions policy dated 2020, indicated hand hygiene should be performed after contact with blood or body fluids and after removing personal protective equipment such as gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 7 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) accurately identify residents as vulnerable and specific measures to be taken by staff to minimize the risk of abuse for two of five residents (R4, 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) 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: R4 R4's cover sheet dated November 10, 2022, indicated R4's diagnosis were Alzheimer's with behaviors, chronic obstructive pulmonary disease (COPD), and celiac disease. R4 resided in the secured dementia care unit.	0 630		

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0 630	Continued From page 8 R4's service agreement dated April 1, 2022, indicated R4 received services for medication management, escorts, meals, bathroom assistance, and reassurance checks. R4's vulnerability assessment dated August 7, 2022, indicated, "resident is not at risk of abuse, resident does not pose a danger to the health and safety of others and is not at risk to abuse themselves." No interventions were identified for abuse prevention. R5 R5's cover sheet dated November 7, 2022, indicated R5's diagnosis were Alzheimer's with behaviors and psychotic disturbances, gait instability, and osteoarthritis. R5 resided in the secured dementia care unit. R5's service agreement dated September 7, 2022, indicated R5 received services for medication management, shower assist, escorts, and laundry. R5's vulnerability assessment dated October 19, 2022, indicated, "resident is not at risk to be abused, resident does not pose a danger to the health and safety of others and is not at risk to abuse themselves." No interventions were identified for abuse prevention. On November 15, 2022, at 1:20 p.m., director of nursing (DON)-A was shown both R4 and R5's vulnerability assessments which indicated neither were vulnerable for abuse. DON-A stated both R4 and R5 were vulnerable, and the assessments should have included interventions. DON-A stated they do not use any other assessment tools for vulnerability.	0 630		

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0 630	Continued From page 9 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all 90 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 640		

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0 640	Continued From page 10 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 14, 2022, at 11:23 a.m., during the facility tour, the surveyor observed the required MAARC posting information and phone numbers were not posted in the facility. Director of nursing (DON)-A and resident service director (RSD)-C both stated the MAARC information was in the welcome packet they distribute but was not posted in the facility. On November 16, 2022, at 7:05 a.m., the surveyor observed the dementia care unit and no MAARC posting information or phone numbers were found. On November 16, 2022, at 1:39 p.m., the surveyor observed the first-floor commons area and no MAARC posting information or phone numbers were found. On November 16, 2022, at 3:00 p.m., DON-A stated they will get the MAARC information posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 11 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all 90 residents receiving services, staff, volunteers and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 680		

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0 680	Continued From page 12 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan provided on November 16, 2022, and unclearly dated, lacked individualized emergency procedures to include the following: - EP plan must be reviewed and updated annually; - EP availability to residents, staff, volunteers and visitors; - arrangement and contracts to re-establish utility services; - procedures for tracking staff and residents; - communication plan must be updated annually; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; and - a communication plan that included: -primary and alternate means of communicating with facility staff and Federal, State, tribal, regional and local emergency management agencies. - EP training and testing program; - EP emergency testing exercises and drills. On November 16, 2022, at 12:55 p.m., licensed assisted living director (LALD)-D showed the surveyor where the EP plan binders were located	0 680		

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0 680	Continued From page 13 in the facility. The EP plan binders were observed in nursing offices, management offices and the facility concierge desk at the main entrance. LALD-D was unable to locate EP plan binders which were out and available for residents, staff, volunteers, family, and visitors. The licensee's Introduction to Emergency Planning Preparedness policy, undated, indicated "At [Licensee] it is imperative that our residents, staff, volunteers, families and visitors are protected In case of an emergency and that the operations of the site are carried out with the least amount of disruption. Unfortunately, every emergency situation cannot always be neatly put into one category for which hard and fast guidelines can be drawn. Individual judgment must be exercised in each emergency situation. Emergency Preparedness Planning Is designed to give those having responsibility for the safety of residents, staff, volunteers, families and visitor guidelines to follow." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	0 690		

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0 690	Continued From page 14 Based on observation, interview, and record review, the licensee failed to document services for two of five residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 R2's service agreement dated April 1, 2022, included but was not limited to bed mobility, repositioning, and lift assist of two. On November 15, 2022, at 11:35 a.m., unlicensed personnel (ULP)-J provided services for R2. R2's record lacked documentation to indicate R2's bed mobility, repositioning, and lift assist of two was provided on the following day: -October 21, 2022, at 12:00 p.m., the documentation had been scribbled out. R4 R4's service agreement dated April 1, 2022, included but was not limited to redirection, meal place set-up, bathroom assist, escort, homemaking, ted socks, appointment reminders, reassurance checks, basic linen change, laundry, and activities of daily living (ADLs). On November 16, 2022, at 8:45 a.m., ULP-N provided services for R4.	0 690		

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0 690	Continued From page 15 R4's record lacked documentation to indicate R4's services had been provided on the following days: -October 31, 2022, at 6:00 a.m., 7:00 a.m., 9:00 a.m., 10:00 a.m., 11:30 a.m., 12:00 p.m., 10:00 p.m., 11:00 p.m.; -November 5, 2022, at 6:00 a.m., 7:00 a.m., 8:00 a.m., 9:00 a.m., 11:30 a.m., 12:00 p.m., 10:00 p.m., 11:00 p.m.; and -November 9, 2022, at 2:00 p.m., 5:00 p.m., 9:30 p.m. On November 15, 2022, at 1:42 p.m., director of nursing (DON)-A was shown R2 and R4's records which lacked documentation of services as listed above. DON-A stated all services should have documentation of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident	0 700		

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0 700	Continued From page 16	0 700		

records were protected against unauthorized disclosure of written records for 69 of 90 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 14, 2022, at 11:29 a.m., during the facility tour with the director of nursing (DON)-A and resident service director (RSD)-C, the 1st floor Commons unit unlicensed personnel (ULP) station was observed to have an unlocked two-doored cabinet. The cabinet contained private resident information in a binder labeled, "Resident Profiles" and contained face sheets for each resident in the Commons unit and included diagnosis, insurance information, pharmacy information, provider information, vaccination status, medication lists, and services received. DON-A stated the two-doored cabinet should have been locked.

On November 14, 2022, at 11:43 a.m., a two-doored cabinet on the Hearth unit was observed and unlocked which contained another binder for the residents on the unit labeled, "Resident Profiles" and contained the same information as the binder found on the Commons unit. ULP-J stated the cabinet on Hearth was never locked.

On November 16, 2022, at 6:55 a.m., the

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0 700	Continued From page 17 Commons unit cabinet was again observed to be unlocked and still contained the binder labeled, "Resident Profiles." ULP-O stated it is always unlocked and had been that way ever since they started working on the unit. ULP-O stated she could understand why it would be a concern as it had a profile book in it with residents' private information and would violate the Health Insurance Portability and Accountability Act (HIPAA). The licensee's AL Access to Resident Records policy dated August 1, 2021, indicated, "Access to paper and electronic resident records will be limited to only the information needed by employees, contractors, other health care providers. If access to electronic records cannot be appropriately limited only to the information that is needed to perform the required task, the employees, contractors or other health care providers shall be given hard copies of the information they need to perform their duties." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 950 SS=F	144.50 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.	0 950		

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0 950	Continued From page 18 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a 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 identify a designated representative for one of five residents (R3). Further the licensee's designated representative form failed to include the required verbatim notice on a document separate from the contract for five of five residents (R1, R2, R3, R4, R5) receiving 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	0 950		

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0 950	Continued From page 19 of the residents). The findings include: R3's records lacked documentation R3 had been given the opportunity to identify or decline a designated representative. Brackets were drawn next to the spaces where a designated representative could be identified but were left blank. A box for resident initials was empty next to, "Initial here if declining to identify a Designated Representative." R1, R2, R3, R4, and R5's record included a designated representative form in the residents' contracts, but did not include required verbatim notice on a document separate from the contract. On November 15, 2022, at 11:55 a.m., director of nursing (DON)-A stated the contract used for R1, R2, R3, R4, and R5 was used for all residents receiving services in the facility and lacked the required verbatim notice on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01500 SS=F	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	01500		

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01500	Continued From page 20 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 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;	01500		

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01500	Continued From page 21 (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 hours of annual training for each 12 months of employment for one of two employees (director of nursing (DON)-A). 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: DON-A was hired on May 1, 2007, and began providing assisted living services on August 1, 2021. DON-A oversees all licensed and unlicensed staff. DON-A's record had three of the eight hours of required training every 12 months. On November 16, 2022, at 10:30 a.m., regional nurse (RN)-M and DON-A acknowledged	01500		

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01500	Continued From page 22 DON-A's record lacked the full eight hours to meet the 12-month annual training requirements. The licensee's Education & Training Policy revised on April 2022, indicated all employees would receive training to meet regulatory requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530		

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01530	Continued From page 23 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (director of nursing (DON)-A). 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) 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: DON-A was hired on May 1, 2007, and began providing assisted living services on August 1, 2021. DON-A oversees all licensed and unlicensed staff. DON-A's employee record lacked two hours of annual dementia care training. On November 16, 2022, at 10:30 a.m., regional nurse (RN)-M indicated the licensee had a four-hour dementia training program all staff received but acknowledged DON-A did not have documentation that it was completed. The licensee's Dementia Training Policy dated	01530		

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01530	Continued From page 24 August 1, 2022, indicated employees will receive training on topics related to dementia care for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	01530		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-B) received the required amount of dementia care training in the required time frame.	01540		

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01540	Continued From page 25 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: The licensee had a current assisted living with dementia care license. ULP-B was hired on March 11, 2019, and began providing assisted living services on August 1, 2021. ULP-B's employee record did not have documentation to indicate ULP-B completed the required eight (8) hours of training on specific dementia care topics within the first 80 working hours of providing services for the licensee. On November 16, 2022, at 10:30 a.m., regional nurse (RN)-M indicated ULP-B did not complete all eight hours of training within the eighty hours of providing care under the assisted living with dementia care requirements and regulations in accordance with 144G statues. RN-M and director of nursing (DON)-A stated they would assign ULP-B the remaining dementia courses to fulfill the requirement. The licensee's Dementia Training Policy dated August 1, 2021, indicated the licensee would provide specialized training in the area of Alzheimer's Disease and Related Disorders to its employees that also meet regulatory	01540		

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	24195	A. BUILDING: _____ B. WING _____	11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY GARDENS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

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01540	Continued From page 26 requirements and timelines. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	01540		
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 prescription medications were stored according to the manufacturer's directions. 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 of the residents). The findings include: On November 14, 2022, at approximately 11:20 a.m., during facility tour, the surveyor, in the presence of director of nursing (DON)-A, licensed practical nurse (LPN)-F, and resident service director (RSD)-C, observed a small medication	01880		

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01880	Continued From page 27	01880		

refrigerator with freezer component inside a small room within the nursing office that contained various medications.

On November 15, 2022, at 8:55 a.m., the surveyor observed the following medications in the refrigerator:
-R7's Latanoprost 0.005% (eye drops);
-R8's Rhoressa 0.02% (eye drops); and
-R9's Humalog insulin-six syringes each containing two units.

The manufacturer's instructions for Latanoprost last reviewed on October 10, 2022, indicated before opening, store the eye drops in the refrigerator (35-46 degrees Fahrenheit (F)).

The manufacturer's instructions for Rhoressa 0.02% last reviewed on December 1, 2021, indicated before opening, store the eye drops in the refrigerator (36-46 degrees F).

The manufacturer's instructions for Humalog insulin last updated on December 14, 2020, indicated before opening, store the insulin in the refrigerator (36-46 degrees F). Do not allow Humalog to freeze.

On November 14, 2022, at approximately 12:00 p.m., the surveyor asked for temperature log and LPN-F indicated there was not one available. LPN-F also indicated there was no thermometer in the refrigerator and was unaware of this requirement. LPN-F indicated a thermometer would be located and placed in the refrigerator.

The licensee's MN AL Medication Management Policy updated on July 18, 2022, indicated all residents will receive proper storage of medications. The policy further indicated all

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01880	Continued From page 28 medications would be stored in a locked box in a cabinet or refrigerator in the resident's unit in areas in which the temperature may not fluctuate to levels that are unsuitable for medication storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for three of five residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01960		

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01960	Continued From page 29 or has the potential to affect a large portion or all of the residents). The findings include: R1 On November 15, 2022, at 9:45 a.m., unlicensed personnel (ULP)-B performed R1's catheter/colostomy care and soft boot removal. R1's prescribed orders dated March 25, 2022, included catheter/colostomy care, wound care, and soft boots. R1's record lacked documentation to indicate R1's catheter/colostomy care was completed as ordered on November 6, 2022, in the evening. R2 On November 15, 2022, at 11:35 a.m., ULP-J checked R2's blood sugar. R2's prescribed orders dated April 21, 2022, included was but not limited to oxygen therapy, blood glucose checks, catheter/colostomy care and wound care. R2's record lacked documentation to indicate the R2's catheter/colostomy care was completed on October 30, 2022, at 2:00 p.m. as scheduled. R2's record lacked documentation to indicate R2's blood sugar was checked on the following days: -October 7, 2022, at 9:00 p.m.; -October 15, 2022, at 11:40 a.m.; -October 23, 2022, at 7:30 a.m. and 4:45 p.m.; and -October 24, 2022, at 4:45 p.m. and 9:00 p.m.	01960		

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01960	Continued From page 30 R4 On November 16, 2022, at 8:45 a.m., ULP-N provided oxygen therapy for R4. R4's prescribed orders dated June 8, 2022, included oxygen therapy. R4's record lacked documentation to indicate R4's oxygen therapy had been applied on the following days: -October 31, 2022, at 6:00 a.m., 2:00 p.m. and 10:00 p.m.; -November 5, 2022, at 6:00 a.m. and 10:00 p.m.; -November 8, 2022, at 2:00 p.m.; and -November 9, 2022, at 2:00 p.m. On November 15, 2022, at 1:45 p.m., director of nursing (DON)-A confirmed R1, R2, and R4's records lacked documentation of their treatments as indicated above. The licensee's MN AL Treatment and Therapy Management Policy dated August 1, 2021, indicated the registered nurse will train staff to document treatment and therapy provided in resident's chart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be	01970		

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01970	Continued From page 31 provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescribed orders for a treatment and therapy, including the clarification on dose and parameters when to remove oxygen for one of five residents (R2). 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: R2's medical record included diagnoses of congestive heart failure, history of pneumonia, chronic kidney disease, and cerebrovascular accident (stroke). On November 16, 2022, at 9:00 a.m., the surveyor observed an oxygen concentrator (device that concentrates the oxygen from room air) in R2's bedroom set at two liters per minute (LPM). R2's prescribed order for oxygen dated August 3, 2022, indicated 1-2 LPM oxygen via nasal cannula (tube that brings oxygen to the nose) for night use. It also indicated 1-2 LPM oxygen via	01970		

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01970	Continued From page 32 nasal cannula as needed (PRN) use. Parameters were to use oxygen if oxygen level was below 90% or if R2 had a coughing episode. No further instructions on when to remove the oxygen or any indication when to use one or two liters of oxygen. R2's record lacked documentation of how many liters were given to R2 daily. During an interview on November 15, 2022, at 1:45 p.m., director of nursing (DON)-A confirmed the order for the above treatment was not clear. DON-A thought the order was for two liters and not a range of 1-2 LPM. DON-A indicated the medication administration record (MAR) should have documented how many liters were given. The licensee's MN AL Treatment and Therapy Management Policy dated August 1, 2021, indicated the licensee would administer treatment and therapies based on the eight rights which are: right resident, right treatment or therapy, right dose, right time, right route, right reason, right form of drug, and right documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills;	02170		

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02170	Continued From page 33 (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activities and preferences plan contained all required content for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02170		

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02170	Continued From page 34 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: R4's cover sheet dated November 10, 2022, indicated R4's diagnoses were Alzheimer's with behaviors, chronic obstructive pulmonary disease (COPD), and celiac disease. R4 resided in the secured dementia care unit. R5's cover sheet dated November 7, 2022, indicated R5's diagnoses were Alzheimer's with behaviors and psychotic disturbances, gait instability, and osteoarthritis. R5 resided in the secured dementia care unit. On November 16, 2022, at 8:45 a.m., director of nursing (DON)-A provided undated My Life Today forms for both R4 and R5 and stated the forms were the closest thing she could find to an activity and preferences plan. DON-A stated all residents in memory care had the same assessment form. R4 and R5's My Life Today forms lacked evaluations including: -current abilities and skills; -comprehensive past interests list; -current abilities and skills; -emotional and social needs; -necessary adaptation for the resident to participate; -occupational or chore related task; -scheduled and planned events; -spontaneous activities for enjoyment to help defuse behavior; -sensory stimulation activities;	02170		

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02170	Continued From page 35 -outdoor activities; -physical activity and physical limitations; and -behavioral interventions. On November 16, 2022, at 3:00 p.m., DON-A stated their evaluations for dementia care residents needed to be more thorough and should have been dated. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Type: Full
Date: *11/15/22*
Time: 10:08:41
Report: 1024221232

Food and Beverage Establishment Inspection Report

Location:
Waverly Gardens
5919 Centerville Road
North Oaks, MN55127
Ramsey County, 62

Establishment Info:
ID #: 0038755
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517654000
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.

3-400B Destroying Organisims: reheating

3-403.11A ** Priority 1 **

MN Rule 4626.0360A Reheat previously cooked, refrigerated, TCS food for hot holding within 2 hours to a temperature of at least 165 degrees F (74 degrees C) for 15 seconds.

CORNED BEEF WAS REHEATED AND MEASURED BETWEEN 124 dF TO 144 dF. ADVISED TO REHEAT ITEM.

Comply By: 11/15/22

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.

MILK IN DISPLAY STAND UP COOLER IN BISTRO AREA MEASURED 45 dF. MILK REMOVED FROM COOLER AND ADVISED TO REPAIR AND MAINTAIN STAND UP COOLER.

Corrected on Site

3-500A Microbial Control: cooling

3-501.15B ** Priority 2 **

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

OBSERVED MULTIPLE CONTAINERS IN COOLER WITH TIGHTLY WRAPPED PLASTIC WRAP. ADVISED TO COMPLY PER ABOVE RULE.

Comply By: 11/15/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS FOR HEARTH KITCHENETTE AREA. PROVIDE AND MAINTAIN.

Comply By: 11/15/22

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED AND REMOVED DARK SUBSTANCE AND DEBRIS FROM ICE BAFFLE OF ICE BIN. ADVISED TO REMOVE ICE AND CLEAN.

Comply By: 11/15/22

3-500A Microbial Control: cooling

3-501.13E

MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.

OBSERVED TIGHTLY SEALED REDUCED-OXYGEN PACKAGED SALMON IN GRILL DRAWER. DISCUSSED CONCERNS FOR BOTULISM. PACKAGES WERE CUT OPEN BY CULINARY DIRECTOR.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HANDWASHING SIGN AT HEARTH AREA SINK. PROVIDE AND MAINTAIN.

Comply By: 11/15/22

Surface and Equipment Sanitizers

Lactic Acid & DDBSA: = 1875/70 at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Utensil Surface Temp: = at 163 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Lactic Acid & DDBSA: = 1875/70 at Degrees Fahrenheit
Location: SANI BUCKET - BISTRO
Violation Issued: No

Utensil Surface Temp: = at 170 Degrees Fahrenheit
Location: HEARTH - DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/PASTA
Temperature: 39 Degrees Fahrenheit - Location: TRAULSEN STAND UP COOLER - EXPO AREA
Violation Issued: No

Process/Item: Cooling/CANTELOUPE
Temperature: 47 Degrees Fahrenheit - Location: DELFIELD COOLER - EXPO AREA
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: DELFIELD COOLER - EXPO AREA
Violation Issued: No

Process/Item: Cold Holding/SLICED TOMATO
Temperature: 36 Degrees Fahrenheit - Location: SAUTEE COOLER
Violation Issued: No

Process/Item: Hot Holding/COOED VEGGIES
Temperature: 152 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Holding/CUT TOMATOES
Temperature: 33 Degrees Fahrenheit - Location: TRUE PREP TOP SALAD COOLER
Violation Issued: No

Process/Item: Cold Holding/SHRIMP
Temperature: 32 Degrees Fahrenheit - Location: TOP LEFT GRILL DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/CHICKEN
Temperature: 30 Degrees Fahrenheit - Location: BOTTOM LEFT GRILL DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/PASTA
Temperature: 41 Degrees Fahrenheit - Location: TOP RIGHT GRILL DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/RAW FISH
Temperature: 36 Degrees Fahrenheit - Location: BOTTOM RIGHT GRILL DRAWER COOLER
Violation Issued: No

Process/Item: Cold Holding/CUT LETTUCE
Temperature: 39 Degrees Fahrenheit - Location: DRAWER COOLER - TRUE PREP SALAD COOLER
Violation Issued: No

Process/Item: Cold Holding/RAW BEEFY
Temperature: 31 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding/TORTILLA SOUP
Temperature: 183 Degrees Fahrenheit - Location: ALTO SHAAM WARMER
Violation Issued: No

Process/Item: Hot Holding/BEEF
Temperature: 178 Degrees Fahrenheit - Location: VULCAN - ARBOR
Violation Issued: No

Process/Item: Hot Holding/TORTILLA SOUP
Temperature: 182 Degrees Fahrenheit - Location: VULCAN - HEARTH
Violation Issued: No

Process/Item: Reheat Temp/CORNED BEEF
Temperature: 124 Degrees Fahrenheit - Location: VULCAN OVEN
Violation Issued: Yes

Process/Item: Cold Holding/CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: DISPLAY COOLER
Violation Issued: No

Process/Item: Hot Holding/TORTILLA SOUP
Temperature: 153 Degrees Fahrenheit - Location: APW WYOTT WARMER - BISTRO
Violation Issued: No

Process/Item: Cold Holding/MILK
Temperature: 46 Degrees Fahrenheit - Location: DISPLAY STAND UP COOLER - BISTRO
Violation Issued: Yes

Process/Item: Cold Holding/HAM
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL COOLER - HEARTH
Violation Issued: No

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

DISCUSSED ALL ORDERS ON SITE WITH MDH HRD NURSING EVALUATORS JOEY KEEN AND ANNA BOHNEN IN ADDITION TO JEFF VANDERSTEEN, THE DIRECTOR OF CULINARY SERVICES.

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- ESTABLISHMENT USES PASTEURIZED EGGS.
- 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.

- UTENSIL SURFACE TEMPERATURE ON ESTABLISHMENT'S DISC THERMOMETER IS 159 dF AND SANITARIAN'S MEASURED 163 dF. ADVISED TO REPAIR DISC OR REPLACE.
- PEST CONTROL.
- HEARTH KITCHENETTE AREA IS USED BY CULINARY STAFF AND NOT RESIDENTS. KITCHENETTE HAS LAMINATE FLOORING, SMOOTH WALLS, NON SMOOTH CEILING, RESIDENTIAL WHIRLPOOL COOLER. OBSERVED TCS FOODS IN COOLER AND DISCUSSED SAME DAY SERVICE OR DISCARD ITEMS AT END OF SERVICE.

IF ANY CUSTOMER COMPLAINS OF ILLNESS, ESTABLISHMENT IS REQUIRED TO NOTIFY THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER: 1-877-366-3455

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 1024221232 of 11/15/22.

Certified Food Protection Manager: JEFFREY L. VANDERSTEEN

Certification Number: FM8119 Expires: 03/08/24

Signed: _____

JEFF VANDERSTEEN
DIRECTOR OF CULINARY

Signed: 

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