Electronically Delivered

November 23, 2022

Administrator
Summerwood Of Chanhassen
525 Lake Drive
Chanhassen, MN 55317

RE: Project Number(s) SL24077015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

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 St. Paul, MN 55164-0970

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,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 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
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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: SL24077015 On November 7 through November 9, 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 60 residents, all of whom received services under the provider's Assisted Living 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 Dementia Care 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.	
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 1 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees, (registered nurse (RN)-A, unlicensed personnel (ULP)-C).	0 650		

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0 650	Continued From page 2 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: RN-A began employment on August 11, 1998. The surveyor reviewed RN-A's employee record and found the most recent annual performance review dated September 18, 2019. RN-A's employee record lacked the following: -documentation of a current annual performance review that identified areas of improvement needed and training needs. ULP-C began employment on December 26, 2018. The surveyor reviewed ULP-C's record and found the most recent annual performance review dated October 2, 2020. ULP-C's employee record lacked the following: - documentation of a current annual performance review that identified areas of improvement needed and training needs. On November 9, 2022, at 12:25 p.m., licensed assisted living director (LALD)-B stated the clinical administrator is the person who usually does the annual performance reviews. They are done during the anniversary month of the employee. LALD-B further stated there was an	0 650		

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0 650	Continued From page 3 interim clinical administrator, then someone was hired in January of this year, and they left a few months later. With all the administrative personnel changes, the annual performance reviews fell through the cracks and did not get completed. LALD-B stated this issue will be the same for all staff in the nursing department. The licensee's undated Employee Records Toolkit for HR Reps document indicated the personnel files would contain evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 4 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required training to residents and employees for fire safety and evacuation. This had the potential to affect all current residents, staff, and visitors to 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, 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 residents). The findings include: On November 9, 2022, at 1:15 p.m., the environmental services director (ESD)-F stated that he was not aware of any training being scheduled or completed for staff or residents. The licensed assisted living director (LALD)-B confirmed that she had not done any training for	0 810		

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0 810	Continued From page 5 staff since August 1, 2021. Review of the fire safety policy showed the following: 1. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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01620	Continued From page 6	01620		

be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for five of five residents (R1, R2, R3, R4, R6).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

On November 11, 2022, at 10:30 a.m., during the entrance conference, registered nurse (RN)-H stated the licensee completed assessments upon admission, at 14 days, every 90 days, and with changes in condition.

R1's record included a 90-day assessment dated March 27, 2022, and a 90-day assessment dated

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01620	Continued From page 7 August 8, 2022, thirteen days after the 90-day assessment was due. R2's record included a 90-day assessment dated December 16, 2021, and a 90-day assessment dated March 22, 2022, six days after the 90-day assessment was due, and a 90-day assessment dated July 13, 2022, 23 days after the 90-day assessment was due. R3's record included a 14-day assessment dated April 22, 2022, and a 90-day assessment dated August 26, 2022, 36 days after the 90-day assessment was due. R4's record included a 90-day assessment dated November 11, 2021, and a 90-day assessment dated March 30, 2022, 49 days after the 90-day assessment was due, and a 90-day assessment dated July7, 2022, 9 days after the 90-day assessment was due. R6's record included a 14-day assessment dated July 29, 2022, three days after the 14-day assessment was due, and a 90-day assessment dated November 3, 2022, seven days after the 90-day assessment was due. On November 8, 2022, at 3:39 p.m., RN-A stated she was away from work during the summer, and reassessments was probably a piece that was hard for the remaining nursing staff to keep up with. On November 9, 2022, at 11:02 a.m., RN-H stated there was some staffing turnover that might have impacted the assessment timing. The licensee's MN AL Nursing Assessment policy dated August 1, 2021, and updated May 3, 2022,	01620		

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01620	Continued From page 8 indicated an RN would complete the following comprehensive nursing assessments: a. initial assessment b. 14-day assessment, completed up to 14-days after start of services c. ongoing assessment completed periodically but no less than every 90-days d. change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940		

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01940	Continued From page 9	01940		

received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R3, 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:

R3
R3 had diagnoses including obstructive sleep apnea, diabetes mellitus, and dementia.

R3's Service Chart for November 2022 indicated, "assist client [resident] to put [continuous positive airway pressure (CPAP-a device worn at night to assist breathing)] mask on and turn machine on. Make sure that CPAP is filled with distilled water. Check if client is wearing her CPAP machine during the night." at 10:00 p.m. and also at 11:00 p.m., effective September 30, 2022.

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01940	Continued From page 10 R3's Service Chart for November 2022 indicated, "assist to put on compression hose" (a garment worn to increase circulation and reduce swelling of the lower leg) at 8:00 a.m., effective October 26, 2022, and "remove compression hose" at 7:00 p.m., daily, effective April 7, 2022. R3's service plan, dated April 3, 2022, indicated R3 received services including assistance with medication monitoring and blood sugar checks. The service plan lacked indication R3 received assistance with compression hose and a CPAP device. R4 R4 had diagnoses including osteoporosis, heart disease, and dementia. R4's Service Chart for November 2022 indicated, "assist to put black knee brace on left knee as shown on picture in medication cabinet. Remove brace at Bedtime." at 7:30 a.m. and 8:00 p.m., daily. R4's service plan, dated October 5, 2022, indicated R4 received services to include assistance with medication management, toileting, laundry, and shower. The service plan lacked indication R4 received assistance with putting on and taking off a knee brace. R3 and R4's records both lacked a treatment and therapy management plan including the following: -A list of the treatment or therapy tasks delegated to unlicensed personnel (ULP); -Procedures to notify a registered nurse (RN) or other licensed health professional when problems	01940		

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01940	Continued From page 11	01940		

arose with treatments or therapies; and
-Resident-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions.

On November 8, 2022, at 2:46 p.m., ULP-G stated sometimes staff assisted R3 with compression hose, and sometimes R3 would put them on herself. ULP-G stated R3 wore a CPAP at night, but would often take the CPAP mask off in the night. ULP-G further stated sometimes R3 slept on the couch in the living room, so could not wear the CPAP at that time. ULP-G stated R4 did not wear a knee brace.

On November 8, 2022, at 3:28 p.m., RN-A stated she had not yet completed the treatment management form for R3 and R4, and agreed the service plans needed updating to include their treatments. RN-A further stated the knee brace for R4 was a newer order, and they were having trouble getting R4 to wear it.

The licensee's MN AL Treatment and Therapy Management Policy, dated August 1, 2021, indicated, "The licensed staff will update the assessment, care plan, functional assessment, and service plan as applicable." The policy further indicated licensed staff would follow the delegated services policy.

The licensee's MN-AL Resident Record policy, dated August 1, 2021, indicated the resident record would include individualized treatment and/or therapy management plan(s), if applicable.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01940	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed and ensured competency of the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for two of two residents (R3, R4).	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01950	Continued From page 13	01950		

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:

R3
R3 had diagnoses including obstructive sleep apnea, diabetes mellitus, and dementia.

R3's Service Chart for November 2022 indicated, "assist client [resident] to put [continuous positive airway pressure (CPAP-a device worn at night to assist breathing)] mask on and turn machine on. Make sure that CPAP is filled with distilled water. Check if client is wearing her CPAP machine during the night." at 10:00 p.m. and also at 11:00 p.m., effective September 30, 2022.

R4
R4 had diagnoses including osteoporosis, heart disease, and dementia.

R4's Service Chart for November 2022 indicated, "assist to put black knee brace on left knee as shown on picture in medication cabinet. Remove brace at Bedtime." at 7:30 a.m. and 8:00 p.m., daily.

On November 8, 2022, at 2:44 p.m., R4 was observed sitting in the hallway. R4 did not have a knee brace visible on the left knee. R4 confirmed she did not have a knee brace on, but stated, "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01950	Continued From page 14 should, because my knees hurt." On November 8, 2022, at 2:46 p.m., ULP-G stated she had worked with R3 and R4. ULP-G stated R3 wore a CPAP at night, but that she had not been trained on assisting R3 with the CPAP. ULP-G was not aware R4 wore a knee brace. On November 9, 2022, at 11:57 a.m., ULP-C stated she worked with R3 and R4. ULP-C stated she was trained to assist with CPAP at a previous job, but did not think she was trained by the licensee. ULP-C further stated she had not been trained on the use of R4's knee brace. On November 9, 2022, at 12:21 p.m. RN-A stated she had provided training to ULPs on assisting R4 with the knee brace as well as assisting R3 with the CPAP, but did not document the training. The licensee's MN AL Treatment and Therapy Management Policy dated August 1, 2021, indicated, "The RN may delegate to resident assistants the task of providing assistance with treatment and therapy if the resident assistants have satisfied the training requirements listed above and if: a. Before performing the procedures, the RN has instructed the resident assistant in the proper methods to administer the treatment and therapy and the resident assistants have demonstrated the ability to competently follow the procedures b. The RN has developed written, specific instruction for each resident c. The RN has communicated with the resident assistants about the individual needs of the resident; and d. The RN has documented that the resident assistants have been trained and have demonstrated competency to follow the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01950	Continued From page 15 procedures. 4. Documentation of each resident assistant's training and competency to assist or administer treatment and therapy will be retained in the personnel record of each staff person who has satisfied the above training and competency requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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 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 prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01970	Continued From page 16 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 had diagnoses including obstructive sleep apnea, diabetes mellitus, and dementia. R3's Service Chart for November 2022 indicated, "assist client [resident] to put [continuous positive airway pressure (CPAP-a device worn at night to assist breathing)] mask on and turn machine on. Make sure that CPAP is filled with distilled water. Check if client is wearing her CPAP machine during the night." at 10:00 p.m. and also at 11:00 p.m., effective September 30, 2022. R3's record lacked a signed prescriber order for CPAP. On November 8, 2022, at 2:46 p.m., ULP-G stated R3 wore a CPAP at night, but would often take the CPAP mask off in the night. ULP-G further stated sometimes R3 slept on the couch in the living room, so could not wear the CPAP at that time. On November 8, 2022, at 3:28 p.m., RN-A stated it took some time to get a signed order, but they got it around the end of September. The order was not provided. The licensee's MN-AL Resident Record policy, dated August 1, 2021, indicated the resident record would include, "orders or prescriptions for medications, treatments or therapies that the agency will be managing."	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(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
01970	Continued From page 17 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *11/09/22*
Time: 13:00:00
Report: 8087221250

Food and Beverage Establishment Inspection Report

Location:

Summerwood Of Chanhassen
525 Lake Drive
Chanhassen, MN55317
Carver County, 10

Establishment Info:

ID #: 0038034
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522945500
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 182 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: DELI MEAT
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: SOUP
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 3 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: SANDWICH PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: SANDWICH PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 36 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Hot Holding: SOUP
Temperature: 169 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER JEREMY V. NGUYEN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING

Food and Beverage Establishment Inspection Report

NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO HFE-NURSE EVALUATOR II RENEE ANDERSON.

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 8087221250 of 11/09/22.

Certified Food Protection Manager: JEREMY V. NGUYEN

Certification Number: FM99741 Expires: 01/31/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JEREMY V. NGUYEN
KITCHEN MANAGER

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us

Report #: 8087221250

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 North Robert Street
Saint Paul, MN

No. of RF/PHI Categories Out	0	Date	11/09/22
No. of Repeat RF/PHI Categories Out	0	Time In	13:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Summerwood Of Chanhassen	Address: 525 Lake Drive	City/State: Chanhassen, MN	Zip Code: 55317	Telephone: 9522945500

License/Permit #: 0038034	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

				COS	R
Safe Food and Water					
30	IN	OUT	(N/A) Pasteurized eggs used where required		
31			Water & ice obtained from an approved source		
32	IN	OUT	(N/A) Variance obtained for specialized processing methods		
Food Temperature Control					
33			Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	(N/A) N/O Plant food properly cooked for hot holding		
35	(IN)	OUT	N/A N/O Approved thawing methods used		
36			Thermometers provided & accurate		
Food Identification					
37			Food properly labled; original container		
Prevention of Food Contamination					
38			Insects, rodents, & animals not present		
39			Contamination prevented during food prep, storage & display		
40			Personal cleanliness		
41			Wiping cloths: properly used & stored		
42			Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/21/22

Inspector (Signature)