Electronically Delivered

April 14, 2025

Licensee
Diamondcrest Senior Living
20500 South Diamond Lake Road
Corcoran, MN 55374

RE: Project Number(s) SL23988016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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 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: SL23988016-0 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 62 resident(s); 34 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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) was developed to include the required content for one of one independent 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was an independent resident and moved into the licensee's facility on June 30, 2023. R2's record lacked an individualized review or assessment of the resident's susceptibility to abuse by other individuals, and the specific measures to be taken to minimize the risk of	0 630		

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0 630	Continued From page 2 abuse to the resident or other vulnerable adults and risk of self-abuse. On March 17, 2025, at 1:11 p.m., licensed assisted living director (LALD)-C stated, "She [R2] does not have an abuse prevention plan because she is independent and independent residents don't get abuse prevention plans." The licensee's Vulnerable Adult Maltreatment policy dated February, 2, 2023, indicated, "An abuse prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services. The individual abuse prevention plan will include: a. An individualized review or assessment of the resident's i.susceptibility to abuse by another individual, including other vulnerable adults ii. risk of abusing other vulnerable adults b. Specific measures to be taken to minimize the risk of abuse to others and self-abuse." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of	0 730		

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0 730	Continued From page 3 the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	0 730		

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0 730	Continued From page 4 Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and began receiving services on July 18, 2018. R1 discharged on November 25, 2024. R1's records included a discharge summary dated November 25, 2024, the discharge summary lacked; - identifying information, including the resident's date of birth, and telephone number; - the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; - names, addresses, and telephone numbers of the resident's health and medical service providers, if known; - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; - the resident's advance directives, if any; - copies of any health care directives, guardianships, powers of attorney, or	0 730		

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0 730	Continued From page 5 conservatorships; - the facility's current and previous assessments and service plans; - all records of communications pertinent to the resident's services; - documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; - documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; - documentation that the resident has received and reviewed the assisted living bill of rights; - documentation of complaints received and any resolution; - a discharge summary, including service termination notice and related documentation, when applicable; and - other documentation required under this chapter and relevant to the resident's services or status. On March 18, 2025, at 3:44 p.m., clinical nurse supervisor acknowledged the discharge summary was lacking information and stated, "When I first started, I just put something in place temporarily as I needed to discharge the resident, so I made something to try to get the job done and it is totally my error and I need to get those other parts added in." The licensee's Move-Out (Discharge/Transfer) Criteria policy, dated April 18, 2005, indicated, "The Community provides the following information to the resident and/or location to which the resident is transferring (upon receiving appropriate consent to release such information):	0 730		

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0 730	Continued From page 6 1. Summary of the resident's stay/condition. 2. List of medications and treatments. 3. A copy of the most recent physician health assessment and date of PPD/chest x-ray; 4. List of diagnoses, diet restrictions and allergies; and 5. The resident's current level of function for self-care." The licensee's policy did not address the other above-mentioned items. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290		

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01290	Continued From page 7 Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one employee (receptionist (R)-E). This had the potential to affect all the residents residing in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R-E began employment on March 25, 2024, to preform secretarial duties. R-E's employee records lacked evidence the licensee submitted a background study for R-E under the current assisted living license and affiliated to the licensee's HFID 23988. On March 18, 2025, at 9:08 a.m., licensed assisted living director (LALD)-C stated, "We looked for the background study for the receptionist and it somehow was overlooked as we did not have her run under either building, so we got her run yesterday and it cleared already so I know that will still be a tag, but I want you to know we are now in compliance." The licensee's Pre-Employment Background Check Process policy dated March 1, 2010, indicated a pre-employment background check would be completed for everyone to whom a	01290		

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01290	Continued From page 8 contigent job offer had been extended. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 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 the registered nurse	01620		

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01620	Continued From page 9 (RN) conducted assessments within 14-days following a residents admission date for two of three residents (R3 and 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee and began receiving services on February 26, 2025. R3's record included an admission assessment dated, February 26, 2025. R3's record lacked a 14-day assessment indicating 21 days had passed since the last assessment. R4 R4 was admitted to the licensee and began receiving services on November 4, 2024. R4's record included an admission assessment dated, November 4, 2024, and a 14-day assessment dated, November 26, 2024, indicating 22 days had passed since the last assessment. On March 17, 2025, at 10:32 a.m., clinical nurse supervisor (CNS)-D stated, "We do the Initial assessment at move in, the 30-day, 90-day and if it warrants then we do that 14-day assessment, otherwise we do the 30 day, but if there have	01620		

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01620	Continued From page 10 been no big changes then we don't do the 14-day assessment and we just do the 30-day, most of them just get the 30-day." The licensee's Resident Assessment and Re-Assessment Process policy dated April 1, 2019, indicated a 14-day assessment would be completed up to 14 days after the start of services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee and began receiving services on July 18, 2018. R1 discharged on November 25, 2024. R1's electronic medication administration record (EMAR) indicated R1 recieved medication management. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On March 18, 2025, at 2:00 p.m., clinical nurse	01910		

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01910	Continued From page 12 supervisor (CNS)-D stated, "We have reached out and requested the disposition of medications from his (R1) new facility, because the family took it with them by accident, so if we can get it back, we will let you know. For the others, they went next door (to a sister facility with a different HFID) so I did not do one for them." The licensee's policy dated April 1, 2019, indicated, "Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
02310	Continued From page 13 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 was admitted to the licensee and began receiving services on February 26, 2025. R3's Doctors orders, signed February 26, 2025, indicated R3 received oxygen services. On March 18, 2025, at 1:10 p.m., surveyor observed in R3's apartment an oxygen concentrator located in R3's living room, and in R3's closet located by the main door there were 3 full oxygen tanks, one large and two smaller tanks. The large tank was secured properly in a base. There was one free standing small oxygen tank and the other small tank was placed inside a wheelchair transport bag and was free standing next to the other two tanks. On March 18, 2025, at 1:18 p.m., licensed assisted living director (LALD)-C acknowledged that all oxygen tanks should be secured properly and stated, "That's due to home health, and we will get it taken care of right away." The licensee's Oxygen Utilization and Storage policy, dated December 1, 2002, indicated, "Used or unused oxygen containers are properly anchored to the bed, floor, wall or carrier to prevent the container from falling over." Minnesota Department of Health (MDH) Oxygen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
02310	Continued From page 14 Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

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

Type: Full
Date: *03/17/25*
Time: 16:00:00
Report: 8087251057

Food and Beverage Establishment Inspection Report

Location:

Diamondcrest Senior Living
20500 South Diamond Lake Road
Rogers, MN55374
Hennepin County, 27

Establishment Info:

ID #: 0037717
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634281981
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 172 Degrees Fahrenheit
Location: DISH MACHINE - UPSTAIRS
Violation Issued: No

Rinse Temperature Gauge: = -- at 194 Degrees Fahrenheit
Location: DISH MACHINE - UPSTAIRS
Violation Issued: No

Max Utensil Surface Temp: = -- at 162 Degrees Fahrenheit
Location: DISH MACHINE - UPSTAIRS
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 0 Degrees Fahrenheit - Location: ICE CREAM FREEZER - UPSTAIRS
Violation Issued: No

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER - UPSTAIRS
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER - UPSTAIRS
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER - UPSTAIRS
Violation Issued: No

Process/Item: Ambient Air
Temperature: 32 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Holding:MILK
Temperature: 32 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER BRITTON RITCH AND NURSE EVALUATOR TESA BROWN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
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 ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

Type: Full
Date: *03/17/25*
Time: 16:00:00
Report: 8087251057
Diamondcrest Senior Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087251057 of 03/17/25.

Certified Food Protection Manager: ASHLEY HACKER

Certification Number: FM95909 Expires: 10/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
BRITTON RITCH
KITCHEN MANAGER

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