DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 3, 2023

Licensee
Silvercrest Properties LLC
6501 Woodlake Drive
Richfield, MN 55423

RE: Project Number(s) SL20869015

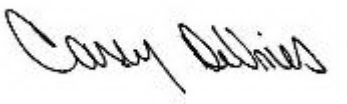
Dear Licensee:

On March 14, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 16, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

Electronically Delivered

January 24, 2023

Licensee
Silvercrest Properties LLC
6501 Woodlake Drive
Richfield, MN 55423

RE: Project Number(s) SL20869015

Dear Licensee:

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

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

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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20869	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	6501 WOODLAKE DRIVE RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37311015-0 On December 12, 2022, through December 13, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 194 residents, with 52 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 52 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 December 12, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (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	0 650		

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0 650	Continued From page 3 by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on August 31, 2021. ULP-C's employee record lacked an annual performance evaluation. On December 13, 2022, between 9:00 a.m. and 10:00 a.m., ULP-C assisted residents with morning cares. On December 13, 2022, at 11:00 a.m., registered nurse (RN)-A stated ULP-C's employee record lacked an annual performance review which identified areas of improvement needed and training needs. RN-A further stated she believed the annual review had been completed and stated she would provide via email. On January 12, 2022, at 10:40 a.m., upon clarification regarding ULP-C's annual review, regional director of operations (RDO)-H stated, "we submitted what we have." No further information was provided.	0 650		

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0 650	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in each sleeping room. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 5 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 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 December 12, 2022, between 12:30 p.m. and 3:00 p.m., survey staff toured the facility with the director of maintenance (M)-J. During the facility tour, survey staff observed no smoke alarms in the bedrooms of apartments 1018, 809, 710, 619, 618, 608, 609, 507, and multiple other apartments. Apartments that were renovated in the most recent building project did not receive smoke alarms in the new bedrooms. M-J verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 6 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 12, 2022, between 12:30 p.m. and 3:00 p.m., survey staff toured the facility with the director of maintenance (M)-J. During the facility tour, survey staff observed the following: 1. Trash chute doors on floors 6, 3, and 2 either had broken or missing hydraulic arms which caused the trash chute to remain open when tested. 2. In the storage rooms on each floor by the laundry, there were numerous locations where recent renovations did not include the replacement of fire-stopping material in rated walls. 3. The ceilings were damaged in the break room, 5th-floor laundry room, and 4th-floor laundry	0 800		

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0 800	Continued From page 7 room. M-J verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 8 (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 develop and maintain fire safety and evacuation plans. 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: During interview on December 12, 2022, at 3:30 p.m., the executive director (LALD)-B stated they had not identified or developed detailed procedures for any unique or unusual resident needs for movement or evacuation. Review of the fire safety policy showed no written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation No further information was provided.	0 810		

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0 810	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This 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: R1, R2, R3, and R4's assisted living contracts contained waivers of liability. The licensee's Assisted Living contract included language which indicated waivers of liability for	0 970		

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0 970	Continued From page 10 the following: "-Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Provider's control. Resident is strongly encouraged to obtain renter's insurance; -Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence.; and -Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises." On December 13, 2022, at 9:13 a.m., regional director of operations (RDO)-H stated the waiver of liability language was included in the contracts for all current residents. RDO-H stated they had an updated contract they would be using going forward for new residents.	0 970		

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0 970	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor 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	01500		

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	20869	A. BUILDING: _____ B. WING _____	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	6501 WOODLAKE DRIVE RICHFIELD, MN 55423

(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
01500	Continued From page 12 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on 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 (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01500		

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01500	Continued From page 13 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on August 31, 2021. On December 13, 2022, between 9:00 a.m. and 10:00 a.m., ULP-C assisted residents with morning cares including toileting, dressing, mobility, and assistance with meals. ULP-C's training record lacked evidence of eight hours of annual training required in the following areas: -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -infection control techniques; -review of provider's policies and procedures; -principles of person-centered planning/service delivery; -hearing loss training (optional); and -dementia training: met two (2) hours annually. On December 13, 2022, at 11:00 a.m., registered nurse (RN)-A stated ULP-C's employee record lacked documentation of annual training requirements. RN-A further stated she believed the annual training had been completed and would provide via email. On January 12, 2022, at 10:40 a.m., upon clarification regarding ULP-C's annual training, regional director of operations (RDO)-H stated, "we submitted what we have." No further information was provided. TIME PERIOD FOR CORRECTION:	01500		

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01500	Continued From page 14 Twenty-One (21) days	01500		
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 medications were stored according to manufacturer's instructions. 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: During the entrance conference on December 12, 2022, at 10:15 a.m., registered nurse (RN)-A stated the licensee provided medication management services to residents residing at the facility. On December 12, 2022, at 11:10 a.m., the licensee's medication refrigerator, located in the third-floor laundry room, was observed with RN-A. The laundry room door was closed, but not	01880		

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01880	Continued From page 15 locked. The medication refrigerator did not have a lock attached, nor was the door secured in any way. The medication refrigerator contained the following medications for residents throughout the facility: - three Humalog KwikPen: 100/milliliter (ml), unopened. - 12 Lantus Solostar (pen) 100/ml, unopened. - four Basaglar KwikPen, unopened. - one Novolin 70/30 FlexPen, unopened. - one Rhopressa 0.2%, unopened. - one Calcitonin nasal spray 200 units, unopened; and - two Latanoprost ophthalmic solution 0.005%, unopened. The Humalog KwikPen manufacturer's guidelines dated October 2022 indicated "unopened Humalog should be stored in a refrigerator (36° to 46° F [2° to 8° C]) and can be used until the expiration date on the carton or label." The Lantus Solostar Pen manufacturer's guidelines revised June 2022 indicated "Keep new pens in the refrigerator between 36°F to 46°F (2°C to 8°C). Do not freeze. Do not use Lantus if it has been frozen. The Basaglar KwikPen manufacturer's guidelines dated December 2022 indicated "store unused pens in the refrigerator at 36°F to 46°F (2°C to 8°C). Do not freeze Basaglar. Do not use if it has been frozen. Unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator." The Novolin 70/30 FlexPen manufacturer's guidelines revised April 2020 indicated "unused pens-store unused pens in the refrigerator at 36° F to 46° F (2° C to 8° C). Do not freeze your	01880		

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01880	Continued From page 16 insulin. Do not use if it has been frozen. Unused pens may be used until the expiration date printed on the label, if the pen has been kept in the refrigerator." The Rhopressa manufacturer's guidelines dated April 18, 2022, indicated store Rhopressa in the refrigerator (36° to 46° F) until opened. After opening, Rhopressa may be kept at 36° to 77° F for up to 6 weeks. If after opening the product is kept refrigerated at 36° to 46 ° F, then the product can be used until the expiration date stamped on the bottle." The Calcitonin nasal spray manufacturer's guidelines revised September 2017 indicated "Store unopened bottle in refrigerator between 2°C-8°C (36°F-46°F). Protect from freezing. Store bottle in use at room temperature between 15°C-30°C (59°F-86°F) in an upright position, for up to 35 days. Each bottle contains at least 30 doses. Discard bottle after 30 doses." The Latanoprost ophthalmic solution manufacturer's guidelines revised August 2011, indicated "store unopened bottle(s) under refrigeration at 2 degrees (°) to 8° Celsius (C) (36° to 46° Fahrenheit (F)). Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." The licensee's Daily/Weekly Temperature Log Refrigerator/Freezer log sheets dated September 16, 2022, through December 12, 2022, were completed fifty-three out of a possible ninety-two opportunities and were signed forty-eight out of the fifty-three times completed. On December 12, 2022, at 2:00 p.m., RN-A stated staff were expected to monitor the	01880		

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01880	Continued From page 17 medication refrigerator temperature daily. RN explained she was aware the medication refrigerator was not secured with a lock due to changes approximately three months prior, but stated it was the licensee's practice to ensure medications were secured in a safe manner at all times. On December 13, 2022, at 1:45 p.m., clinical director (CD)-F stated any refrigerator which contained medications for resident use was always expected to be locked when not being used. In addition, CD-F, stated to ensure the efficacy of the medications stored in the refrigerator, a daily temperature needed to be completed and logged. The licensee's Medication Management /Medication Refrigerator Maintenance policy dated August 1, 2021, indicated medications which required refrigeration per manufacturer guidelines would be kept in a locked refrigerator when not in use and a refrigerator temperature log would be kept with the refrigerator and checked daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890		

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01890	Continued From page 18 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained, including the opened date for time sensitive medication storage 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) 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's had a primary diagnosis of diabetes type two. R3's service plan dated December 2, 2022, indicated R3 received services which included assistance with medication management. The medication administration record (MAR) for December 1, 2022, through December 12, 2022, indicated R3 was administered prefilled pen (a combination of 70 percent (%) intermediate-acting insulin and 30% short-acting insulin), 27 units every morning and ten units with dinner. On December 13, 2022, at 10:30 a.m., the surveyor observed R3's Novolin 70/30 FlexPen opened and without a label to indicate the date staff first used the insulin or when the insulin	01890		

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01890	Continued From page 19 would expire. Unlicensed personnel (ULP)-C confirmed the insulin was opened and lacked identification of the date opened or when it expired after opening. ULP-C stated she was trained to put a date on the label of a multi-use medication with a shortened expiration date. On December 13, 2022, at 2:45 p.m., clinical director (CD)-F stated insulin pens should be dated when opened and first used. CD-F further explained staff who administered medications were taught the practice during new employee orientation (NEO) and that was the expectation of all staff who were trained to administer medications. Novolin 70/30 FlexPen's manufacturer's instructions updated November 2022, indicated the FlexPen should be discarded after 28 days, even if the FlexPen has insulin remaining. The licensee's Medication storage policy dated August 1, 2021, indicated medications would be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the	02040		

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02040	Continued From page 20 property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. During interview on December 12, 2022, at 3:30 p.m., the executive director (LALD)-B stated they had not completed a hazard vulnerability assessment on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced	02110		

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02110	Continued From page 22 by: Based on interview and record review, the licensee failed to provide documentation of policies and procedures for assisted living with dementia care were provided to residents and the residents' legal and designated representatives at the time of move in for four of four residents (R1, R2, 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 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, R2, R3, and R4's records lacked documentation that policies and procedures for assisted living with dementia care were provided to residents and residents' legal and designated representatives at the time of move in. On December 13, 2022, at 8:39 a.m., regional director of operations (RDO)-H stated none of the current residents' records included confirmation of receipt of dementia care policies and procedures. The licensee's Dementia License Policies dated December 6, 2021, indicated due to the licensee's Assisted Living with Dementia Care license additional, "policies and procedures must be provided to residents and the residents' legal and designated representatives by the time of move-in. The policies can be provided in electronic format if desired."	02110		

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02110	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/12/22*
Time: 13:15:59
Report: 1021221393

Food and Beverage Establishment Inspection Report

Location:
Silvercrest Properties Llc
6501 Woodlake Drive
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0037901
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6127464703
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.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

ONE OPEN GALLON OF MILK IN MEMORY CARE UPRIGHT COOLER AND TWO OPEN GALLONS OF MILK IN THE RIC #1 COOLER THAT WERE OPENED AND HELD IN ESTABLISHMENT WERE MISSING A DATE MARK. DISCUSSED DATE MARKING WITH DIRECTOR. STAFF WILL DATE MARK GALLONS OF MILK.

Comply By: 12/12/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF QUATERNARY AMMONIUM (QUAT) SANITIZER IN MEMORY CARE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 12/19/22

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

A CLEAR SPRAY BOTTLE WITH AN UNKNOWN CHEMICAL WAS FOUND IN THE KITCHEN WITHOUT A LABEL. STAFF LABELED THE SPRAY BOTTLE WITH SANITIZER. CORRECTED

ON-SITE.
Comply By: 12/12/22

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

STAFF WASHING THEIR HANDS IN THE MEMORY CARE KITCHEN OBSERVED TOUCHING THE FAUCET HANDLES WITH THEIR HANDS AFTER WASHING THEIR HANDS. DISCUSSED WITH DIRECTOR THAT STAFF SHOULD AVOID RECONTAMINATION OF THE HANDS BY USING A PAPER TOWEL.

Comply By: 12/12/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

CONCENTRATION OF SANI BUCKET IN MEMORY CARE MEASURED 0PPM. A NEW SANI BUCKET WAS PROVIDED DURING INSPECTION WITH AN APPROVED SANITIZING SOLUTION OF 200PPM. CORRECTED ON-SITE.

Comply By: 12/12/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: SANI BUCKET, MEMORY CARE
Violation Issued: Yes

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKEY, MEMORY CARE *CORRECTED
Violation Issued: No

Final Utensil Surface Temp: = at 173 Degrees Fahrenheit
Location: DISH MACHINE, MEMORY CARE
Violation Issued: No

Sink & Surface Sanitizer: = 272PPM at Degrees Fahrenheit
Location: SANI BUCKET, MAIN KITCHEN
Violation Issued: No

Final Utensil Surface Temp: = at 174 Degrees Fahrenheit
Location: DISH MACHINE, MAIN KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 139 Degrees Fahrenheit - Location: BEAN AND HAM SOUP - HOT WELLS, MEMORY CARE

Food and Beverage Establishment Inspection Report

Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: BRATWURST PATTY - HOT WELLS, MEMORY CARE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - ARCTIC AIR UPRIGHT, MEMORY CARE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT MELON - ARCTIC AIR UPRIGHT, MEMORY CARE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - RIC #1 COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CUT FRUIT - RIC #1 COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: SOUP - SOUP WELL
Violation Issued: No

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

Process/Item: Cooling
Temperature: 50 Degrees Fahrenheit - Location: CREAM OF TURKEY SOUP - WALK-IN COOLER
Violation Issued: No

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

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR OF DINING SERVICES, LES JOHNSON AND HEALTH REGULATION DIVISION NURSE EVALUATORS, JOEY KEEN AND MARY BRUESS.

PER CONVERSATION WITH LES, FOOD IS MADE FOR SAME DAY SERVICE.

THE BISTRO IS CURRENTLY CLOSED. BEFORE RE-OPENING THE BISTRO MAKE SURE THAT STAFF CLEAN AND SANITIZE ALL FOOD CONTACT SURFACES OF EQUIPMENT.

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 1021221393 of 12/12/22.

Certified Food Protection Manager: LESLIE O. JOHNSON

Certification Number: FM8306 Expires: 08/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LES JOHNSON
DIRECTOR OF DINING SERVICES

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
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Melissa.Ramos@state.mn.us