DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 30, 2023

Licensee
Silvercrest Properties LLC
8501 Flying Cloud Drive
Eden Prairie, MN 55344

RE: Project Number(s) SL21963015

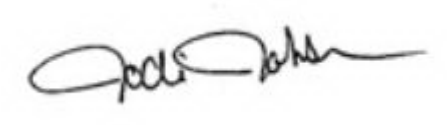
Dear Licensee:

On March 15, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 23, 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,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

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Electronically Delivered

March 1, 2023

Licensee
Silvercrest Properties LLC
8501 Flying Cloud Drive
Eden Prairie, MN 55344

RE: Project Number(s) SL21963015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21963	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	8501 FLYING CLOUD DRIVE EDEN PRAIRIE, MN 55344

(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: SL21963015 On December 19, through Decmeber 23, 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 72 active residents receiving services under the 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 with Dementia Care. 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at 11:30 a.m., licensed assisted living director (LALD)-C identified herself as the facility's current LALD. The Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed with LALD-C. The BELTSS website indicated LALD-C held a current assisted living director license (issued June 07, 2021; expires October 31, 2023). The website did not indicate LALD-C as the Director of Record for the licensee, this section was left blank. LALD-C stated the BELTSS website should have been updated to identify herself as the Director of Record for this facility.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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 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 19, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 a working smoke alarm in the sleeping room of resident apartment unit A11 and the interconnection of the required smoke alarms	0 780		

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0 780	Continued From page 4 for the one-bedroom apartment unit A410. This has the potential to directly affect 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 of the residents). The findings include: On December 22, 2022, approximately from 11:00 a.m. to 3:00 p.m., survey staff toured the facility with the director of environmental services (DES)-E and the director of environmental services (DES-D). During the tour, survey staff observed the following while the DES-E tested the smoke alarms: 1) Inside the one-bedroom apartment unit A11, the required smoke alarm located in the sleeping room failed to sound when the DES-E tested the smoke alarm. 2) The smoke alarms in the one-bedroom apartment unit A410 were not interconnected so the actuation of one alarm causes all alarms inside the apartment unit to sound. The finding was evident as the DES-E tested the smoke alarms and each alarm sounded local and failed to sound the other smoke alarm in the unit for proper notification. The DES-E and the DES-D verified the findings. On December 22, 2022, at approximately 3:45	0 780		

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0 780	Continued From page 5 p.m., during the exit interview, the DES-D and DES-E acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) 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 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. 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). On December 22, 2022, approximately from 11:00 a.m. to 3:00 p.m., survey staff toured the	0 800		

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0 800	Continued From page 6 facility with the director of environmental services (DES)-E and the director of environmental services (DES-D). During the tour, survey staff observed the following: 1. The required exit courtyard gate for the courtyard was locked and obstructed by a tree in the fenced-in courtyard limiting a means of egress during a fire or similar emergency to a public way. The finding was evident as the exit door inside the building and the facility ' s evacuation plan directed residents and employees to exit into the locked courtyard during an emergency. Survey staff asked the DES-D and DES-E if the lock was a mag-lock that will fail open during a fire alarm and the DES-D stated that it was not. The DES-D and DES-E confirmed the finding. 2. The mop sink faucet connected to a chemical soap dispenser in the kitchen lower level floor was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. The finding was confirmed by the DES-E as he stated that may be the only unit that was missed. 3. The laundry room wall had a large sheetrock removed that need to be sealed to maintain the fire rating of the room. In addition, the corridor wall near the dining room behind the set of the double door had damaged sheetrock that needs to be patched/repaired to maintain the fire rating of the corridor. 4. The floor shower tile in room A312 had broken grout/sealant. On December 22, 2022, at approximately 3:45 p.m., during the exit interview, the DES-D and DES-E acknowledged the above findings. No further information was provided.	0 800		

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0 800	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty (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. (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.	0 810		

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0 810	Continued From page 8 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the complete content on the fire safety and evacuation plan and fire protection procedures for residents. This has the potential to directly affect the safety of all residents receiving care, 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 of the residents). The findings include: On December 22, 2022, at approximately 3:00 p.m., survey staff received the facility's fire safety and evacuation documentation, evacuation drill, and training documentation from the director of environmental services (DES)-E and the director of environmental services (DES)-D. A documentation review and interview were performed with the DES-D and DES-E at approximately 3:30 p.m. 1. The posted building layout plan throughout the building lacked the identification of sleeping locations and the number of sleeping rooms. 2. The documentation lacked fire protection procedures for the residents. The resident handbook emergency documentation provided for the review was incomplete and only included pages 6 and 8.	0 810		

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0 810	Continued From page 9 On December 22, 2022, at approximately 3:45 p.m., during the exit interview, the DES-D acknowledged the above findings and agreed to update the building floor layout to reflect the sleeping room locations and the number of sleeping room requirements. Additional documentation, "SP_Community Wide Drill_Local Fire and Rescue", drill dated 11/8/2022, at 1:15 p.m., was received via email on 12/22/2022 at 4:28, 2022, and the same document was received again on 12/23/2022 at 8:15 a.m. from the licensed assisted living director-C. In addition, on 12/23/2022, at 6:31 p.m., the same drill documentation was received via email from the DES-D. Additional building plan information was received via email from the DES-D on the building fire separation areas, wall separation, and fire resistive rating on 12/23/2022, at 7:24 p.m. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 810		
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	01880		

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01880	Continued From page 10 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 19, 2022, at 11:30 a.m., licensed assisted living director (LALD)-C, stated the licensee provided medication management services to residents residing at the facility. On December 19, 2022, at 1:13 p.m., the licensee's single medication refrigerator, was observed with a registered nurse, (RN)-A. The medication refrigerator contained the following medications for residents throughout the facility: -Basaglar (five) KwikPens,100/milliliter (ml), unopened. -Acetaminophen (five) supp 650 milligrams (mg) -Latanoprost ophthalmic solution (one) 0.005%, unopened. Recommendations for medications storage as follows: -Basaglar KwikPen: Manufacture's Guidelines (Lilly) December 2022, "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. Store the Pen you	01880		

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	21963	A. BUILDING: _____ B. WING _____	12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	8501 FLYING CLOUD DRIVE EDEN PRAIRIE, MN 55344

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01880	Continued From page 11	01880		

are currently using at room temperature (up to 86°F [30°C]) and away from heat and light."
-Acetaminophen suppository: 1998-2023 Mayo Foundation for Medical Education and Research." Store in a closed container at room temperature, away from heat, moisture, and direct light. Keep from freezing. (The suppositories may be store in the refrigerator, but do not freeze them."
-Latanoprost ophthalmic solution: Pfizer Manufacturing, revised August 2011, "Store unopened bottle(s) under refrigeration at 2° to 8°C (36° to 46°F). Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks."

On December 19, 2022, at 1:40 p.m., a resident's (R-1) medication storage was observed. In the refrigerator in R1's room a single Bascular KwikPen,100/ml noted. RN-A stated the following:
-the Bascular KwikPen had two ml remaining
-the Bascular KwikPen was used to provide insulin to R1 on December 19, 2022
-a thermometer was not available to check the refrigerator temperature
-logs were not documented for R1's refrigerator

On December 19, 2022, at 2:00 p.m., RN-A stated medication temperatures were logged in daily by staff through the computer application Rtasks, however when observed the temperature documentation for the medication refrigerator was not completed on Saturdays or Sundays each week. RN-A stated the facility did not log the temperatures on the weekend due to the system was not "set up that way." RN-A explained it was the licensee's practice to store opened insulin (any form) at room temperature or per manufactures' guidelines. RN -A stated she oversaw the medication storage process. RN-A stated, "We have work to do."

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01880	Continued From page 12 The Medication Storage policy, dated August 1, 2021, indicated: -when medications were managed and stored by SilverCrest Properties, medications would be kept securely locked and stored per manufacturer's directions. -medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). On December 20, 2022, at 11:50 a.m., the licensed assisted living director (LALD)-C stated all refrigerators used to store resident medications were expected to be monitored for temperature daily, including weekends. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 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 the document review and interview, the	02040		

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02040	Continued From page 13	02040		

licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.

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 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 clients).

The findings include:

On December 22, 2022, at approximately 3:00 p.m., survey staff received the facility ' s hazard vulnerability assessment plan, Kaiser Permanente, HVA Summit Place 2021 (undated) from the director of environmental services (DES)-E and the director of environmental services (DES-D) for review. Document review indicated the following:

1.The licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the undated assessment documentation did not include site-specific safety risks.

2.The plan documentation did not include mitigations to protect memory care residents from harm. Prevention measures to mitigate risks from

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02040	Continued From page 14 the identified potential hazard and vulnerability assessment must be developed and documented in the plan. The DES-D confirmed the above findings. On December 22, 2022, at approximately 3:45 p.m., during the exit interview, the DES-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	02040		
02310 SS=G	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 (R1) who utilized consumer bed rail "Bedcane." This resulted in an immediate order issued on December 20, 2022, at approximately 6:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02310		

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02310	Continued From page 15 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 : R1 admitted July 24, 2021, R1 received licensed assisted living facility services beginning on August 1, 2021. An email from Physical Therapy (PT) dated June 6, 2022, identified PT recommended a "lower box spring" and "bedcane." R1's "Visit Note Report" from PT indicated the following: On June 20, 2022, the report identified R1 was being seen by PT included a "Therapy Subjective" section which identified R1's new four inch "box spring has arrive but is not yet installed. He plans to have maintenance install the box spring and bedcane." The "Therapy Assessment/Plan" section identified R1 "has obtained recommended equipment for the bed to increase safety but needs to install this." The report identified the resident required additional therapy to include "safe bed mobility and assessment of new equipment." On June 29, 2022, the report identified the "bed rail and new lowered boxspring have arrived and been installed. Client [resident] reports the bed is easier to get in/out of but would like to go over how to use the bed rail properly." The report identified R1 was at "high risk" for further decline without therapy including falls. "Recommendation provided for a lower height boxspring" and "an addition of a non-entrapment bed rail. Client has implemented these changes and demonstrates	02310		

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02310	Continued From page 16 increased ease and safety getting in/out of bed." R1's assessment dated November 11, 2022, identified diagnoses to include history of falling, long-term use of anticoagulants (blood thinners), and Diabetes Mellitus (metabolic disease in which the body's inability to produce any or enough insulin results in elevated levels of glucose in the blood). Although the assessment identified R1 was independent with transferring and bed mobility, the "Safety" section of the assessment identified R1 had a "standard [consumer] bed" and a "bedcane" for bed mobility. The "Bed Safety Zones (Hospital Bed System ONLY)" section noted, "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed". Although the assessment identified use of a "bed cane," the assessment lacked evidence the "bed cane" was assessed for safety, including proper installation, reference and review of manufacturer guidelines for the equipment, and monitoring for safe use of the "bedcane"; In addition, the assessment lacked evidence the resident and/or family were educated about the risks and benefits of using the "bedcane." R1's service plan dated October 19, 2022, indicated R1 received services including medication management, blood glucose two times daily, and blood pressure monitoring monthly. On December 20, 2022, at 9:49 a.m., R1's full-sized consumer bed was observed to have a bed rail device labeled "Stander" attached to the right side of the bed. The bed was not occupied. A registered nurse (RN-A) explained this device was not considered by the licensee to be a bed	02310		

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02310	Continued From page 17 rail, therefore was not assessed and maintained regularly for safety. On December 20, 2022, at 11:19 a.m. an undated copy of the "Bedcane" by Stander manufacturer guidelines was provided to the evaluator by registered nurse (RN)-A. The first page included a picture of the device, referenced the device as a "rail" and gave specifications of requiring a 12 inch or 16 inch mattress. The device was to be secured to the bed frame with a safety strap. The bottom of page two included a warning section which identified "Entrapment and Fall hazard" and "Suffocation and Strangulation hazard" the specifications identified specific areas to focus such as, but not limited to: gaps in and around this product "can entrap and kill," ensure product was "secure to the bed" and outline specific factors which could increase the risks of using the Bedcane including specific diagnoses and conditions. The specifications gave further detailed notations on instillation of the bed rail, entrapment, physical and mental conditions, and external factors that could affect the safe use of the bed rail. On December 20, 2022, at 11:23 AM director of environmental Services (DES)-D stated, "We do not put bed rails on, we consider it [bed rail] a restraint" and stated, "I believe family" installed the bedcane. "We do not put on any rails of any kind, we don't adjust, we do not look at them every 90 days, we don't do anything with bed rails." DES-D stated they were not aware of any side rails in the facility and further stated there was "no system in place to maintain any of the bed rails by maintenance." At 12:36 p.m. the safety strap was observed to be attached to the bed frame.	02310		

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02310	Continued From page 18 On December 20, 2022, at 12:53 PM. LALD-C stated R1's son installed the bed rail on June 26, 2022. LALD-C verified R1's record lacked documentation of a bed rail assessment, the resident education about the risks and benefits of using a bed rail, and verified the device was not checked to determine if it was installed according to the manufacturer's guidelines. LALD-C further explained PT was contracted by facility to recommend "non entrapment" bed rail, and PT should have communicated to the RN, to complete an assessment and have a system in place to ensure safety. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's [resident's] physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's Side Rails policy dated October 27, 2022, indicated "Staff from SilverCrest Properties (SCP) communities will determine if the side rail is attached to a hospital bed or to a consumer bed. The RN will recommend an occupational therapy consult to determine if an assistive device is needed to make a recommendation for the best device". The policy further indicated, " PROCEDURE-ASSESSMENT OF SIDE RAILS ON A CONSUMER BED:	02310		

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02310	Continued From page 19 1. Determine the manufacturer and model of the rail(s). 2. Check the Consumer Product Safety Commission (CSPC) website to verify the rail(s) have not been recalled. 3. Verify the rail(s) have been installed per manufacturer's guidelines. 4. Verify the rail(s) are secure (not wobbly). 5. Determine the purpose of rail(s)- verify it is not acting as a restraint. 6. Educate the resident and family about the risks and benefits of using a side rail." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines;	02310		

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02310	Continued From page 20 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *12/19/22*
Time: 13:00:00
Report: 8041221367

Food and Beverage Establishment Inspection Report

Location:
Silvercrest Properties Llc
8501 Flying Cloud Drive
Eden Prairie, MN55344
Hennepin County, 27

Establishment Info:
ID #: 0038014
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529229540
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.

3-500E Microbial Control: time as a control

3-501.19A ** Priority 2 **

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

PER DISCUSSION, ESTABLISHMENT IS HOLDING TCS FOODS SUCH AS CUT MELON AND SANDWICH TOPPINGS ON ICE ON THE SERVICE LINE DURING SERVICE. DEVELOP TIME AS A PUBLIC HEALTH CONTROL POLICY PROCEDURES OR STORE THESE ITEMS USING MECHANICAL REFRIGERATION.

Comply By: 12/19/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SOME OF THE CABINETRY IN THE BEVERAGE SERVICE AREA OUTSIDE OF THE MAIN KITCHEN IS IN POOR REPAIR. NOTE: ESTABLISHMENT IS PLANNING TO UPGRADE TO STAINLESS STEEL CABINETRY.

Comply By: 03/19/22

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

VINYL BASE COVING IS MISSING IN A SECTION OF THE DRY STORAGE ROOM.

Comply By: 03/19/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

FIRST FLOOR MEMORY CARE HAND SINK DOES NOT HAVE A HANDWASHING SIGN.

Comply By: 12/26/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sani bucket- cookline
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp. sink dispenser
Violation Issued: No

Utensil Surface Temp.: = at 171 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler: sliced cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: ribs
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: ham
Violation Issued: No

Process/Item: Hot Holding
Temperature: 148 Degrees Fahrenheit - Location: metro warmer: chicken noodle soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: upright cooler- cookline: turkey sausage
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: service line cooler main kitchen: ambient air
Violation Issued: No

Process/Item: Hot Holding
Temperature: 188 Degrees Fahrenheit - Location: service line soup warmer: chicken noodle soup
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Re-Heating
Temperature: 167 Degrees Fahrenheit - Location: steamer: pulled pork
Violation Issued: No

Process/Item: Cooking
Temperature: 168 Degrees Fahrenheit - Location: stove: chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: 2 door cooler: yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: 2nd floor memory care cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: 1st floor memory care cooler: milk
Violation Issued: No

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

Inspection was completed with Dan Stephenson (Director of Dining Services). The lead Health Regulation Division Nurse Evaluator was Safia Hassan.

Establishment has a commercial kitchen and two serving kitchens in memory care.

Discussed the following:
Employee illness policy and log
Reportable diseases
Foodborne illness complaints
Vomit clean-up
Cleaning and sanitizing procedures
Handwashing
Glove-use and bare hand contact
Re-heating and cooling procedures
Time as a public health control- fact sheet sent to operator
Violations on this report

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 8041221367 of 12/19/22.

Certified Food Protection Manager: Daniel John Stephenson

Certification Number: fm111582 Expires: 04/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Dan Stephenson
Director of Dining Services

Signed: Sarah Conboy

Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us