Electronically Delivered

May 7, 2025

Licensee
Shorewood Landing
6000 Chaska Road
Shorewood, MN 55331

RE: Project Number(s) SL33359016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 may be 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.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33359	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD LANDING	6000 CHASKA ROAD SHOREWOOD, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33359016-0 On March 24, 2025, through March 28, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 94 residents; 55 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 R3 was admitted on May 8, 2022, with diagnoses of deep vein thrombosis (blood clot), tachycardia (fast heart rate), and seizures.	0 630		

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0 630	Continued From page 4 On March 25, 2025, at 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. R3's Service Plan dated January 7, 2025, indicated R3's services included medication administration. R3's IAPP completed on January 3, 2025, indicated R3 was not at risk to be abused but needed help from another person to take their medication. R3's IAPP lacked assessment of the person's risk of abusing others. R4 R4 was admitted on June 9, 2022, with a diagnosis of dementia. On March 25, 2025, at 8:15 a.m., the surveyor observed ULP-B assist R4 with dressing and toileting. R4's Service Plan dated November 4, 2024, indicated R4's services included medication administration. R4's IAPP completed on March 17, 2025, indicated R4 was at risk to be abused; and the plan of action indicated, due to dementia, resident resided in memory care and had 24/7 staff available. R4's IAPP lacked specific measures to be taken to minimize the risk of abuse to that person; and lacked an assessment of the person's risk of abusing others. On March 27, 2025, at 10:08 a.m., clinical nurse supervisor (CNS)-D provided to the surveyor a policy on nursing assessment and stated the policy included information on IAPP; and stated the licensee did not have a separate policy on	0 630		

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0 630	Continued From page 5 IAPP. On March 27, 2025, at 2:45 p.m., CNS-D stated the licensee would need to provide re-education on vulnerability assessments due to having some new nurses. CNS-D stated everyone who received care would be at risk for abuse and they would need more specific interventions to minimize that risk. The licensee's MN AL Nursing Assessment policy dated May 3, 2022, indicated a comprehensive assessment would include an assessment of the resident's areas of vulnerability and susceptibility to maltreatment; and whether the resident posed a risk to other vulnerable adults. The policy did not include the requirement to have specific measures to minimize the risk of abuse to that person. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 6 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to 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 the residents). The findings include: The licensee's undated EP lacked evidence of the following required content: - development of EP policies and procedures; - policies and procedures for medical documents; and - methods for sharing information.	0 680		

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0 680	Continued From page 7 On March 27, 2025, at 1:01 p.m., licensed assisted living director (LALD)-C showed the surveyor documentation of an EP annual review for 2025. LALD-C stated they could not find the EP annual review for 2024 and 2023; and they had requested someone from corporate to pull this information for them since they were required to updated corporate every year for their EP annual reviews. The surveyor did not receive the EP annual reviews for 2023 or 2024. On March 27, 2025, at 2:28 p.m., LALD-C stated it was an oversight for the missing content and would update the licensee's EP. LALD-C stated the licensee did not have a policy and procedure for EP, but they followed the licensee's Site Annual Emergency Operations Preparedness Plan (EOPP) Review for their policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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

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0 730	Continued From page 9 discharged residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when 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: The licensee's Discharge Resident/Client Roster dated September 1, 2024, to March 24, 2025, indicated R5 had an admission date of May 8, 2022, and a date of discharge on October 23, 2024. On March 26, 2025, at 11:28 a.m., the surveyor requested R5's discharge summary and medication disposition. On March 26, 2025, at 11:39 a.m., clinical nurse supervisor (CNS)-D stated the licensee did not have a discharge summary or medication disposition for R5. CNS-D stated the licensee would re-educate the nurses on the need for a discharge summary and medication disposition for all resident discharges. The licensee's AL Discharged Resident policy dated January 23, 2024, indicated staff would complete all discharge steps and have discharge summary completed prior to final chart filing. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with regional environmental manager (EM)-G, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: EXIT DOOR LOCKING: The secure memory care unit inside the facility was locked with electromagnetic locks and key-code pads that locked all the exit doors from the direction of exit travel. There was not an emergency release button to release all locked	0 775		

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0 775	Continued From page 11 doors to open in the direction of exit travel installed anywhere in the facility. EM-G stated they did not have a remote emergency release button to release all the electromagnetic locks on the exit doors. The egress control locking system at all exterior doors shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. These deficient conditions were visually verified at the time of discovery by EM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33359	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD LANDING	6000 CHASKA ROAD SHOREWOOD, MN 55331

(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
0 780	Continued From page 12 (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 that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally) The findings include: On March 25, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with regional environmental manager (EM)-G. The surveyor asked EM-G to initiate a test of the smoke alarms in apartment 312. Upon testing, it was found that the smoke alarms in apartment 312 were not interconnected. These deficient conditions were visually verified by EM-G accompanying on the tour.	0 780		

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0 780	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a	01620		

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01620	Continued From page 14 comprehensive nursing assessment within the required 90-day timeframe for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 R3 was admitted on May 8, 2022, with diagnoses of deep vein thrombosis (blood clot), tachycardia (fast heart rate), and seizures. On March 25, 2025, at 11:32 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. R3's Service Plan dated January 7, 2025, indicated R3's services included medication administration. R3's record included 90-day nursing assessments dated July 9, 2024, October 10, 2024, and January 3, 2025. The assessment completed October 10, 2024, indicated 93 days had passed since the prior assessment completed on July 9, 2024. R4 R4 was admitted on June 9, 2022, with diagnosis of dementia. On March 25, 2025, at 8:15 a.m., the surveyor	01620		

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	33359	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD LANDING	6000 CHASKA ROAD SHOREWOOD, MN 55331

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01620	Continued From page 15 observed ULP-B assist R4 with dressing and toileting. R4's Service Plan dated November 4, 2024, indicated R4's services included medication administration. R4's record included 90-day nursing assessments dated July 31, 2024, November 4, 2024, and February 7, 2025. The assessment completed November 4, 2024, indicated 96 days had passed since the prior assessment completed on July 31, 2024; and the assessment completed on February 7, 2025, indicated 95 days had passed since the prior assessment completed on November 4, 2024. On March 27, 2025, at 2:35 p.m., clinical nurse supervisor (CNS)-D stated the licensee's electronic medical system had a reminder set to complete the assessments every 90 days. CNS-D stated the licensee would correct this going forward to ensure all assessments would be completed prior to 90 days. The licensee's MN AL Nursing Assessment policy dated May 3, 2022, indicated a registered nurse (RN) would complete a comprehensive ongoing assessment periodically but no less than every 90 days. The policy failed to indicate a reassessment could not exceed 90 days from the previous assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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	33359	A. BUILDING: _____ B. WING _____	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 16	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for two of two discharged residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an at a widespread scope (when	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 17 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 The licensee's Discharge Resident/Client Roster dated September 1, 2024, to March 24, 2025, indicated R1 had an admission date of January 29, 2024, and a date of discharge on January 20, 2025. R1's Discharge Care Plan dated January 23, 2025, indicated R1 had been discharged on January 20, 2025; and had received service of medication administration; and medications were given to R1's power of attorney (POA). R1's Discharge Care Plan included section, Med Disposition Summary, which indicated two medications were disposed on February 14, 2025, due to spilled, dropped, or spoiled. R1's record lacked evidence of documentation of disposition of medications to include the medications that were given to the POA at discharge, the prescription number, quantity, and the names of the staff and other individuals involved in the disposition of medication. On March 26, 2025, at 11:23 a.m., clinical nurse supervisor (CNS)-D stated they were not able to locate the medication disposition for R1. CNS-D stated the licensee's process was to count the medications and have two signatures at discharge. CNS-D stated perhaps the form had gotten lost or misplaced. The surveyor showed CNS-D, the medication disposition summary on R1's Discharge Care Plan and the documentation of only two medications that indicated they were	01910		

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01910	Continued From page 18 destroyed on February 14, 2025, due to spilled, dropped, or spoiled by hazardous waste collection container. CNS-D stated they believed that nurse did not know what disposition meant as they were a float nurse. R5 The licensee's Discharge Resident/Client Roster dated September 1, 2024, to March 24, 2025, indicated R5 had an admission date of May 8, 2022, and a date of discharge on October 23, 2024. On March 26, 2025, at 11:28 a.m., the surveyor requested R5's discharge summary and medication disposition. On March 26, 2025, at 11:39 a.m., clinical nurse supervisor (CNS)-D stated the licensee did not have a discharge summary or medication disposition for R5. CNS-D stated the licensee would re-educate the nurses on the need for a discharge summary and medication disposition for all resident discharges. The licensee's AL Discharged Resident policy dated January 23, 2024, indicated the nurse would provide medications to resident or destroy medications and document in the electronic medical record. Also, the policy indicated the nurse would print a medication disposition and place in the physical chart. The policy did not include the required contents of a medication disposition. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

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

Type: Full
Date: *03/24/25*
Time: 12:00:00
Report: 8041251040

Food and Beverage Establishment Inspection Report

Location:
Shorewood Landing
6000 Chaska Road
Shorewood, MN55331
Hennepin County, 27

Establishment Info:
ID #: 0038527
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524017444
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

DICED CHICKEN HELD ON ICE ON THE SERVING LINE AT 47F. STORE USING MECHANICAL REFRIGERATION WHEN NOT IN USE UNLESS AN APPROVED TIME AS A PUBLIC HEALTH CONTROL POLICY IS APPROVED. ANY LEFTOVER CHICKEN WILL BE DISCARDED AFTER LUNCH SERVICE.

Comply By: 03/24/25

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

SANITIZER CONCENTRATION IN WIPING CLOTH BUCKETS IN PREP AREA MEASURED 0 PPM. CORRECTED ON SITE. BUCKETS WERE REFILLED WITH SANITIZER.

Comply By: 03/24/25

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 168 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

S/S Lactic Acid DDBSA: = 272 at Degrees Fahrenheit
Location: 3 comp sink
Violation Issued: No

S/S Lactic Acid DDBSA: = 0 ppm at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: soup well: cheesy potato
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: cookline prep cooler: hard boiled egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cookline prep cooler: deli ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: cookline prep cooler:
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: 2 door cooler: cream pie
Violation Issued: No

Process/Item: Thawing
Temperature: 29 Degrees Fahrenheit - Location: walk-in cooler: gravy
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: walk-in cooler: chicken wild rice soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: walk-in cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: 2 door cooler: cut melon
Violation Issued: No

Process/Item: Cold Holding
Temperature: 47 Degrees Fahrenheit - Location: iced container: diced chicken
Violation Issued: Yes

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

Inspection was completed with the food service manager, Casandra Lee. Rhawnie Quinehan was the lead Health Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen and prepares meals on site for residents.

Discussed the following:
- Employee illness policy and logging requirements

- Handwashing
- Glove-use and bare hand contact
- Pasteurized shell eggs
- Cooling and reheating procedures
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

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 8041251040 of 03/24/25.

Certified Food Protection Manager: Casandra Lee

Certification Number: 30838 Expires: 03/29/28

Inspection report reviewed with person in charge and emailed.

Signed: _____
Casandra Lee

Signed: Sarah Conboy

Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us