Electronically Delivered
October 13, 2025

Licensee
Cherrywood Big Lake
171 Henry Road
Big Lake, MN 55309

RE: Project Number(s) SL28114016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 4, 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, 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:

0775 - 144g.45 Subd. 2. (a) - 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 $500.00**. 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,

Kelly Thorson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(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: SL28114016 On September 2, 2025, through September 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living Facility 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.	
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 1 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 requirements of the Minnesota State Fire Code. 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 of the residents). Findings include: On a facility tour on September 3, 2025, from 10:00 a.m. to 11:15 a.m., with housing manager (HM)-F and licensed assisted living director (LALD)-C, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: CARBON MONOXIDE ALARMS/ DETECTION There was a single station carbon monoxide alarm installed in the mechanical room that was not tied into the building fire alarm system for notification. The carbon monoxide alarm sounded locally in the mechanical room at the location of the activated alarm only.	0 775		

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0 775	Continued From page 2 There were not carbon monoxide alarms installed within ten feet of all sleeping rooms within the facility. Carbon monoxide detection and or alarm systems are required to be installed to notify the building occupants of the presence of carbon monoxide. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. SPECIAL EXIT DOOR LOCKING ARRANGEMENTS There was controlled exit door hardware requiring a code to exit installed at all exit doors leading to the exterior exit path. The fire safety and evacuation plan (FSEP) employee procedures failed to include operating procedures for operation of the controlled exit locking system in writing in the FSEP employee procedures. During the facility tour HM-F, and LALD-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=C	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 3 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content.	0 810		

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0 810	Continued From page 4 This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 3, 2025, at 9:15 a.m., housing manager (HM)-F and licensed assisted living director (LALD)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of residents for evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the	0 810		

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0 810	Continued From page 5 event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on September 3, 2025, at 9:30 a.m., LALD-C, stated the resident actions required in the event of a fire or similar emergency were not included in the FSEP because the residents would not be able to comprehend the actions required. LALD-C, also stated the unique needs for evacuation of each individual resident were not provided and available because all residents need extra help. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the	01540		

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01540	Continued From page 6 training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure two of two direct care staff (unlicensed personnel (ULP)-E) and (licensed practical nurse (LPN)-D) received the required two hours of topics related to mental illness and de-escalation training in the required time frame. 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 the residents). The findings include: ULP-E began employment on April 24, 2025, to provide direct care to the facility residents. LPN-D began employment on November 28, 2023, to provide direct care to the facility residents. ULP-E and LPN-D's employee records lacked evidence of having completed two hours of topics	01540		

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01540	Continued From page 7 related to mental illness and de-escalation training within the required time frame. On September 2, 2025, at 2:10 p.m. licensed assisted living director (LALD)-C stated staff have not yet completed mental illness and de-escalation training. It was something that was missed and they will assign it for all staff. On September 3, 2025, at 1:36 p.m. the surveyor received an email from LALD-A indicating LPN-D was assigned the training on September 2, 2025, and it is due October 13, 2025. On September 3, 2025, at 2:08 p.m., the surveyor received an email from LALD-A indicating ULP-E was assigned the training on September 2, 2025, and it is due October 13, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
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 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time	01890		

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01890	Continued From page 8 sensitive medications included the opened or expiration date. 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 September 3, 2025, at 11:40 a.m., the surveyor along with licensed practical nurse (LPN)-G observed the medication cabinet in R4's room. R4's latanoprost eye drops were not labeled with an opened date. Manufacturer's instructions for latanoprost indicate bottles should be stored at room temperature after opening for six weeks. On September 3, 2025, at 11:45 a.m., LPN-G stated the eye drops should have been labeled with an opened date. On September 3, 2025, at 2:42 p.m., clinical nurse supervisor (CNS)-B stated eye drops should be labeled with opened dates, staff are trained to do that every time. The licensee's Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by [the facility] medications will be kept securely locked and stored per manufacturer's directions.	01890		

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01890	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment or therapy management plan to include the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: R2 was admitted on December 4, 2023. R2's individualized treatment or therapy management plan dated June 24, 2025, indicated R2 received assistance from the facility with oxygen management. R2's treatment administration record (TAR) dated September 2025, indicated supplemental oxygen 1-4 LPM (liters per minute) per NC (nasal cannula) as needed for hypoxia, apply if oxygen is less than 90% of SOB (short of breath). The record lacked specific resident instructions, procedures for notifying a nurse when a problem arises, and was not included on the service plan. R3 was admitted on June 5, 2025. R3's individualized treatment or therapy	01940		

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01940	Continued From page 11 management plan dated June 6, 2025, indicated R3 received assistance with blood glucose monitoring, c-pap (continuous positive airway pressure) assistance, specialty diet, vital signs, weight monitoring, and wound care. R3's TAR dated September 2025, indicated c-pap assistance, daily weights, wound care, and compression socks assistance. R3's c-pap and compression stocking assistance were not included on the service plan. On September 3, 2025, at 2:25 p.m., clinical nurse supervisor (CNS)-B stated service plans should be changed right away with any changes in services, R3 had just received orders last week for the compression stockings so they had not yet changed the service plan, but the c-pap care should have been on there and was missed. CNS-B further stated R2's oxygen management should have been on the service plan and staff should have written instructions of what to do and when to call the nurse. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated for each resident at [the facility] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. [the facility] will develop and maintain a current individualized treatment or therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 12 b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment or therapy received. f. Verification that all treatment and therapy was administered as prescribed. g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of two residents (R2) who utilized oxygen. This practice resulted in a level two violation (a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 13 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 September 2, 2025, at 1:45 p.m., the surveyor along with clinical nurse supervisor (CNS)-B observed oxygen storage for R2 and found one oxygen tank on the floor, unsecured. On September 2, 2025, at 1:45 p.m., CNS-B stated hospice had brought in the tanks and they should all be secured in holders and they will call and get one today. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. The licensee's Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

CHERRYWOOD BIG LAKE
171 HENRY ROAD
Big Lake, MN 55309
Sherburne County
Parcel:

Phone:

License Info

License: HFID 28114

Risk:
License:
Expires on:
CFPM: Thomas T. Gerth
CFPM #: 113634; Exp: 9/13/2025

Inspection Info

Report Number: F7930251096
Inspection Type: Full - Single
Date: 9/2/2025 Time: 11:18:08 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F7930251096 from 9/2/2025

Tina Remmele

Establishment Representative

Tina Remmele,
Public Health Sanitarian 3
320-223-7302
tina.remmele@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

CHERRYWOOD BIG LAKE
Big Lake
County/Group: Sherburne County

Inspection Info

Report Number: F7930251096
Inspection Type: Full
Date: 9/2/2025
Time: 11:18:08 AM

New Record: Product/Item/Unit: ZUPPA SOUP**; Temperature Process:** Cold-Holding
Location: Upright Cooler--140 Kitchen at 34 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler--140 Kitchen Dining Room at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: ZUPPA SOUP**; Temperature Process:** Cold-Holding
Location: Upright Cooler--150 Kitchen at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler--150 Kitchen at 38 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: CREAM CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler--150 Kitchen Dining Room at 41 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

CHERRYWOOD BIG LAKE
Big Lake
County/Group: Sherburne County

Inspection Info

Report Number: F7930251096
Inspection Type: Full
Date: 9/2/2025
Time: 11:18:08 AM

New Record: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen--140 Kitchen **Equal To**
Comment: 100PPM
Violation Issued?: No