Electronically Delivered

March 27, 2025

Licensee
Arbor Lakes Senior Living LLC
12001 80th Avenue North
Maple Grove, MN 55369

RE: Project Number(s) SL30754016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LAKES SENIOR LIVING LLC	12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369

(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: SL30754016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 163 residents; 80 residents whom received 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 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 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene (HH) for one of four employees (unlicensed personnel (ULP)-L). 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: ULP-L was hired October 23, 2023, and provided direct care services for residents. On February 11, 2025, at 7:10 a.m., the surveyor observed ULP-L with gloves on, preparing food in	0 510		

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0 510	Continued From page 2 the secured unit's kitchen. ULP-L removed their gloves, and entered R1's room. ULP-L provided socks to R1, and without performing HH, donned clean gloves, and prepared and administered morning medications to R1. ULP-L removed gloves, and exited R1's room. Without performing hand hygiene, ULP-L escorted R1 to the dining room and then performed HH. On February 11, 2025, at 7:22 a.m., the surveyor observed ULP-L with gloves on, assist R2 with perineal care while using the stand lift. Without changing gloves or performing HH, ULP-L pulled up R2's incontinent brief and pants, moved R2 in the stand lift from the bathroom to the bedroom, lowered R2 into their wheelchair, detached the stand lift sling from R2, moved the lift to R2's kitchen area, and then removed gloves. Without performing HH, ULP-L placed R2's hearing aide in the right ear, placed a call pendant around R2's neck, and adjusted R2's wheelchair. ULP-L stated they were out of gloves and they would have to retrieve more gloves. ULP-L used a mobile phone to place a call to coworkers, then exited R2's room. ULP-L retrieved gloves from the community kitchen area, and without performing HH, donned clean gloves. ULP-L returned to R2's room, prepared R2's oral medication, administered R2's eye drops, and removed gloves. Without performing HH, ULP-L placed a napkin over the top of R2's oral medication, escorted R2 to the dining room, placed R2 at the dining room table, and performed HH. On February 11, 2025, at 8:29 a.m., ULP-L stated they were trained to perform HH between each service provided, with meals, and wash hands for 20 seconds. ULP-L stated the licensee had one hand sanitizer for the entire unit. ULP-L stated they were trained to wash their hands after	0 510		

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0 510	Continued From page 3 removing gloves however, they "must have missed it." On February 11, 2025, at 8:59 a.m., registered nurse (RN)-F stated caregivers were trained to wash their hands before donning gloves and after removing gloves. RN-F stated caregivers should be washing their hands at the sink and some carry a small hand sanitizer. On February 11, 2025, at 9:08 a.m., clinical nurse supervisor (CNS)-B stated caregivers took a two-day in person training upon hire. CNS-B stated they were trained to perform HH when they removed gloves and after they complete a task. CNS-B stated, "at some point we did have pocket sanitizers as well." The Centers for Disease Control and Prevention (CDC) document titled Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended you should perform hand hygiene: - immediately before touching a patient; - before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated after gloves were disposed of in the proper receptacle, hands would be rewashed. The licensee's 8.09 Hand Washing policy dated	0 510		

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0 510	Continued From page 4 August 1, 2021, read, "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: - Before, during, and after preparing food - Before eating food - Before and after caring for someone who is sick - Before and after treating a cut or wound - After using the toilet - After changing diapers or cleaning up after someone who has used the toilet - After blowing your nose, coughing, or sneezing - After touching an animal or animal waste - After handling pet food or pet treats - After touching garbage" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 5 Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has not 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 potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 11:30 a.m., during a self-guided facility tour, the surveyor observed the facility entry area and two units' common areas, and noted there was no required 911 emergency numbers posted in common areas. On February 10, 2025, at 2:10 p.m., regional vice president of operations (VP)-E stated the required content was not posted as required. VP-E further stated he was under the impression 911 was only required to be posted by telephones and not required to be posted in common areas. The licensee's 2.21 Emergency/911 policy dated August 1, 2021, directed staff to call 911 to summon for assistance and aid when handling emergency situations. Discovering an emergency situation. The policy lacked direction to post the 911 emergency number in common areas and near telephones.	0 640		

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0 640	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP)-L).	0 650		

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0 650	Continued From page 7 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: ULP-L was hired on October 23, 2023, to provide direct care services to residents. On February 11, 2025, at 7:22 a.m., the surveyor observed ULP-L assist R2 with incontinence care. ULP-L's record lacked the following required content: - annual performance review; - annual training which included assisted living bill of rights and a review of providers policies and procedures; - training which included recognizing physical, emotional, cognitive, and development needs of the resident. On February 11, 2025, at 12:22 p.m., licensed assisted living director (LALD)-A stated they were unable to locate ULP-L's performance evaluation and clinical nurse supervisor (CNS)-B told them they completed a performance evaluation but did not know where the documentation was located. LALD-A stated the licensee reviewed the bill of rights and policies and procedures at a in person staff meeting every February. LALD-A stated the licensee had different leadership at the last annual meeting and due to this they were unable to locate the meetings attendance for 2024.	0 650		

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0 650	Continued From page 8 On February 11, 2025, at 12:35 p.m., registered nurse (RN)-C stated they believed the licensee's dementia care courses covered recognizing physical, emotional, cognitive and developmental needs of a resident. The surveyor requested to observe the course content that covered the topics listed above. Although requested the surveyor did not receive the course content to review prior to the completion of the survey. On February 11, 2025, at 12:57 p.m., ULP-L stated they received the training listed above and they received a performance evaluation by a nurse in 2024. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated each employee record would include all training and in-service education required and/or provided including record of competency evaluations as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 9 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a TB history and symptom screening and baseline TB testing for one of two employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The facility TB risk assessment dated November 1, 2024, indicated the facility was a low risk setting for TB transmission. ULP-H was hired May 9, 2024, and provided direct cares and services for residents of the facility. ULP-H's employee record included baseline TB screening tool for health care workers and risk	0 660		

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0 660	Continued From page 10 history questionnaire dated August 16, 2024, which was completed greater than 90-days after hire. ULP-H's employee record also included a report from Health Partners clinic dated October 10, 2023, which indicated ULP-H was being treated for latent TB, had no evidence of active TB, and was cleared for working with patients. ULP-H's employee record lacked a TB history and symptom screen completed upon hire. ULP-H's employee record further lacked either: 1. documentation of treatment completion, and a correlated negative chest x-ray, or 2. negative TST or TB blood test within 90-days before hire or upon hire, as required. On February 11, 2025, at 1:35 p.m., licensed assisted living director (LALD)-A stated ULP-H's employee record lacked TB screening upon hire, documentation that latent TB treatment had been completed, and any results of TB skin testing or TB blood testing. LALD-A indicated she was responsible for ensuring employee records included TB history and symptom screening and baseline TB testing. LALD-A further stated she was not aware of all the TB requirements. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.	0 660		

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0 660	Continued From page 11 The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Furthermore, the policy indicated screening would be conducted as follows: 1. New staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff would have a two-step tuberculin skin test (TST) or a TB blood test, such as the QuantiFERON or the T-SPOT and following the most current tuberculosis infection control guidelines issued by the CDC. 3. No staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first TST were read and documented, or a negative TB blood test result was received. 4. Staff TB screening results would be kept in each employee medical record. 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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(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
0 680	Continued From page 12 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; (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 maintain a written emergency preparedness plan (EPP) 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, 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

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0 680	Continued From page 13 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan binder dated August 2021, lacked evidence of the following required content: - quarterly review of missing resident plan; - emergency plan (EP) program patient; - process for EP collaboration; - alternative sources of energy to maintain sewage and waste disposal; - policies and procedures for medical documents; - roles under a waiver declared by secretary; - emergency official contact information; - methods for sharing information; and - emergency prep testing requirements. On February 10, 2025, at 1:24 p.m., during an interview with licensed assisted living director (LALD)-A, regional vice president of operations (VP)-E, and regional director of operations (DO)-D, LALD-A stated the licensee reviewed their missing resident plan one time since August 2024. VP-E stated the missing resident plan should be reviewed once per year. VP-E stated they were unaware of the requirement to review the missing resident plan quarterly. VP-E stated they were instructed to keep waiver 1135 out of the EPP because it was only required for skilled nursing facilities (long term care). The surveyor requested EP testing documentation, but did not receive any prior to survey exit. The licensee's 9.02 Disaster Planning and Emergency Preparedness dated August 21, 2021, indicated the licensee would have in place a general emergency preparedness plan that was in alignment with facility's requirements to comply	0 680		

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0 680	Continued From page 14 with Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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) 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	0 810		

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0 810	Continued From page 15 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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 potential to affect a large portion or all of the residents). The findings include: On February 11, 2025, at 2:35 p.m., regional vice president of operations (VP)-E 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 licensees FSEP titled, Emergency Preparedness Plan, dated August 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine,	0 810		

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0 810	Continued From page 16 and Extinguish or Evacuate) but had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The plan failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. During an interview on February 11, 2025, at 2:50 p.m., VP-E stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 17 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document medication administration for two of four residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION DOCUMENTED, NOT ADMINISTERED R1's diagnoses included Parkinson's disease, hypertension, mild cognitive impairment and brief psychotic disorder (a sudden onset of psychotic behavior that lasts less than a month). R1's service plan effective January 21, 2025, indicated R1 received services including assistance with medication management. The service plan indicated, "Give resident medications from his mediplanner [medication pill organizer]." R1's medication set up documentation dated February 1, 2025, through February 28, 2025, indicated the following medications were set up by licensed practical nurse (LPN)-G through February 12, 2025:	01760		

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01760	Continued From page 18 -Aricept 5 milligrams (mg) one tablet, -bupropion extended release 150 mg one tablet, -carbidopa-levodopa 25 mg-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. R1's medication administration record (MAR) dated February 1, 2025, through February 28, 2025, included the following morning medications to be administered at 7:45 a.m., on February 11, 2025: -Aricept 5 mg one tablet, -bupropion extended release 150 mg one tablet, -carbidopa-levodopa 25 mg-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. A total of 4 tablets and one capsule were scheduled to be administered. On February 11, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-L assist R1 with medication administration. R1 removed medications from the medication cupboard, opened the Tuesday morning slot in the mediplanner, placed the medication into the medication cup. ULP-L then counted the medications to six, out loud, and administered five pills and one capsule to R1. ULP-L documented the following medications were administered on the MAR: -Aricept 5 mg one tablet, -bupropion extended release 150 mg one tablet, -carbidopa-levodopa 25-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. On February 11, 2025, at 8:29 a.m., ULP-L stated they did not believe they administered an additional pill to R1. ULP-L stated one of the pills should have been written on the MAR to give two	01760		

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01760	Continued From page 19 pills versus one pill and they believed the LPN did not update the instructions on the MAR. On February 12, 2025, at 8:25 a.m., Clinical nurse supervisor (CNS)-B stated the additional tablet in R1's medication was a multivitamin the family brought to the facility. CNS-B stated a LPN added it to the mediplanner after talking with family. CNS-B stated there was not an order for the multivitamin, they removed it from the mediplanner, and once an order was received, they would add the multivitamin back to the mediplanner. MEDICATION / TRANSCRIPTION ERROR R2 admitted to the licensee on July 13, 2018, and began receiving assisted living services. R2's diagnoses included dementia and unilateral primary osteoarthritis. R2's service plan signed January 6, 2025, indicated R2 received services including assistance with medication management, and activities of daily living (ADLs). On February 11, 2025, during a continuous observation from 7:10 a.m., to 8:29 a.m., the surveyor observed ULP-L assisting residents with personal cares and medication administration. At 7:22 a.m., ULP-L assisted R2 to transfer out of bed and to the bathroom, assisted R2 with ADLs, perineal cares, and dressing. ULP-L then transferred R2 into his broda chair (a reclining chair on wheels). At approximately 7:50 a.m., ULP-L removed medications from R2's medication cupboard, and place the following into the medication cup: -two tablets of Tylenol 500 mg, -one tablet of cranberry 500 mg,	01760		

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01760	Continued From page 20 -one tablet loratadine 10 mg, -one half tablet methimazole 5 mg, -one tablet of senna s 8.6 mg / 50 mg, -one tablet of Seroquel 25 mg, and -one tablet sertraline 25 mg . ULP-L then initialed R2's MAR, indicating the above medications were administered on February 11, 2025, as well as: -dorzolamide/timolol 2 percent (%)/ 0.5 % (for glaucoma); and -Voltaren gel 1 % gel (topical, for pain) apply four grams (g) to knees. ULP-L then crushed the oral medication and put it back into the medication cup. ULP-L administered eye drops into both of R2's eyes. ULP-L then assisted R2 to the dining room, and administered the above-listed oral medications with applesauce. ULP-L documented administration of medications prior to administering them to R2, and was not observed to administer Voltaren gel to R2's knees. On February 11, 2025, at 8:24 a.m., ULP-L stated they applied R2's Voltaren gel earlier in the morning when they toileted R2 and that was why they signed the MAR indicating R2 had received the medication. ULP-L stated they were trained to document after the medication was administered, and they did document the Voltaren gel after administration. On February 11, 2025, at 8:59 a.m., RN-F stated ULP were trained for medication administration at a two day in person training. RN-F stated ULP shadowed other ULP after the training was complete. RN-F stated ULP were trained to administer medication and then document on the MAR that it was administered. On February 11, 2025, at 9:11 a.m., CNS-B	01760		

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01760	Continued From page 21 stated ULP were trained to document medication administration right after the medications were given or refused. If a medication was refused ULP were trained to circle their initials on the MAR. The licensee's 7.20 Medication & Treatment Record-Documentation & Refusal policy dated August 1, 2021, indicated the time must be documented in the resident's medication record after providing medication assistance or administration. In addition, documentation of medication administration would be completed by the person who performed the task immediately after the medication administration was completed. The licensee's 7.11 Medications-Prescribed, Not Prescribed & OTC policy dated August 1, 2021, indicated the licensee would determine whether the facility shall require a prescription for all medications the provider manages. The facility will inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be	01770		

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01770	Continued From page 22 done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's diagnoses included Parkinson's disease, hypertension, mild cognitive impairment and brief psychotic disorder (a sudden onset of psychotic behavior that lasts less than a month). R1's service plan effective January 21, 2025, indicated R1 received services including assistance with medication management. The service plan indicated, "Give resident medications from his mediplanner [medication pill organizer]." R1's medication set up documentation dated February 1, 2025, through February 28, 2025, indicated the following medications were set up by licensed practical nurse (LPN)-G through February 12, 2025: -Aricept 5 milligrams (mg) one tablet, -bupropion extended release 150 mg one tablet,	01770		

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01770	Continued From page 23 -carbidopa-levodopa 25 mg-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. R1's medication administration record (MAR) dated February 1, 2025, through February 28, 2025, included the following morning medications to be administered at 7:45 a.m., on February 11, 2025: -Aricept 5 mg one tablet, -bupropion extended release 150 mg one tablet, -carbidopa-levodopa 25 mg-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. A total of 4 tablets and one capsule were scheduled to be administered. On February 11, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-L assist R1 with medication administration. R1 removed medications from the medication cupboard, opened the Tuesday morning slot in the mediplanner, placed the medication into the medication cup. ULP-L then counted the medications to six, out loud, and administered five pills and one capsule to R1. ULP-L documented the following medications were administered on the MAR: -Aricept 5 mg one tablet, -bupropion extended release 150 mg one tablet, -carbidopa-levodopa 25-100 mg one tablet, -coenzyme Q-10 200 mg capsule, and -lisinopril 10 mg one tablet. On February 11, 2025, at 8:29 a.m., ULP-L stated they did not believe they administered an additional pill to R1. ULP-L stated one of the pills should have been written on the MAR to give two pills versus one pill and they believed the LPN did not update the instructions on the MAR.	01770		

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01770	Continued From page 24 On February 12, 2025, at 8:25 a.m., Clinical nurse supervisor (CNS)-B stated the additional tablet in R1's medication was a multivitamin the family brought to the facility. CNS-B stated a LPN added it to the mediplanner after talking with family. CNS-B stated there was not an order for the multivitamin, they removed it from the mediplanner, and once an order was received, they would add the multivitamin back to the mediplanner. On February 12, 2025, at 10:15 a.m., registered nurse (RN)-C stated any medication that was set up by the facility was required to be documented on. RN-C stated it was an error on the facility that they did not document the medication being set up. The licensee's 7.08 Medication Management - Dosage Box Setup policy dated August 1, 2021, indicated when a licensed nurse had completed setting up the medications into the dosage box the set-up would be documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff.	02090		

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02090	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee of the assisted living facility with dementia care failed to maintain the dignity, independence, and comfort during meal time, for residents of the secured unit. 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: EAST SECURED UNIT On February 11, 2025, 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-L escort R1 from their apartment to the east secured unit dining room, and set up R1's food. ULP-L left the dining room to attend to another resident. The surveyor observed no other staff members in the dining room after ULP-L left. On February 11, 2025, at approximately 7:45 a.m., ULP-L was observed assisting R2 with cares. ULP-L contacted the other team member via phone to see if they were located in the kitchen and they responded they were not near the kitchen. ULP-L left R2's apartment to retrieve gloves from the kitchen located next to the dining room. The surveyor observed four residents, three residents at one table and one resident at a separate table, all with food placed in front of them. Two residents were eating independently,	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LAKES SENIOR LIVING LLC	12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369

(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
02090	Continued From page 26 while R5 and R7 were not eating the food in front of them. No other staff were present in the dining area. ULP-L returned to R2's apartment. On February 11, 2025, at 8:08 a.m., ULP-L escorted R2 to the dining room. No other staff were present in the dining area. R5 was observed sleeping in their seat at the table. R7 was not eating and was looking around the dining room. R6 was coughing continuously. ULP-L checked on R6 due to the continuous coughing which continued until 8:14 a.m. The surveyor observed R5 and R7's plates showed very little to no food eaten. ULP-M entered the kitchen area. ULP-M asked if R6 was ok due to the coughing. -At 8:22 a.m., more than 30 minutes after R5 was served, ULP-M sat down and began to assist R5 with eating. ULP-M stated when they passed through the dining room, they assisted R5 to eat. ULP-M stated at breakfast R5 could occasionally feed themselves, and required more assistance near the end of the meal. ULP-M stated this morning R5 was not as alert as they normally were. ULP-M stated R5 always needed feeding assistance for lunch. -At 8:24 a.m., ULP-L stated they went back and forth from the dining room so they could continue to get residents up for the day. On February 11, 2025, at 8:41 a.m., the surveyor observed ULP-M assisting R7 with eating. On February 11, 2025, at 8:50 a.m., ULP-M stated there normal morning routine was to assist a resident in the morning, bring them to the dining room, prepare food for the resident, bring the food to the resident, and then leave the dining room to get another resident ready for the day. ULP-M stated it was "busy" in the morning and all ULPs would go back and forth from resident	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LAKES SENIOR LIVING LLC	12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369

(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
02090	Continued From page 27 rooms to the dining room. ULP-M stated, "at lunch we can be more in the dining room but during the breakfast it is too busy to sit in there with them." WEST SECURED UNIT On February 11, 2025, at 7:24 a.m., the surveyor observed one resident walking around the dining area and three residents sitting at the dining area table, with no staff present. On February 11, 2025, at 8:59 a.m., registered nurse (RN)-F stated after a ULP assisted the resident with morning cares, they would bring the resident to the dining room, set up their breakfast, and let the resident eat while they went to a different room to get another resident up for the day. RN-F stated ULPs were entering and exiting the dining room throughout the morning. On February 11, at 9:16 a.m., clinical nurse supervisor (CNS)-B stated ULPs would get a resident up for the day, and provide them with breakfast. CNS-B stated the staff prepared the meal for the resident and if the resident was able to eat independently, they would leave the dining room to continue to complete cares on other residents. CNS-B stated caregivers were supposed to take turns staying with the residents in the dining room. CNS-B stated they previously had a dedicated health unit coordinator to stay with the residents in the dining room, but, were told they no longer could utilize the employee to watch the dining room. The licensee's 12.02 Dining Service policy dated August 1, 2021, indicated the licensee would help to create a dining service that was efficient and organized to make mealtimes enjoyable.	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LAKES SENIOR LIVING LLC	12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369

(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
02090	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02090		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel (ULP) followed the resident care plan, to include dining procedures, for one of three 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: R3's Service Plan dated February 11, 2025, indicated R3 received services that included assistance with medication management, turning	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
02320	Continued From page 29 and repositioning, safety checks, toileting, laundry, dressing/grooming, peri-care, catheter care, showers, monthly vital signs, and registered nurse assessments. The service plan indicated, "Bring out to dining area to be fed-is not to be fed in her apartment" and "assist her with feeding while you feed other residents." On February 11, 2025, between 8:00 a.m., and 8:30 a.m., the surveyor observed ULP-I assist R3 with dressing, grooming, peri-care, medication administration, and meal preparation of granola with milk and a banana. ULP-I then assisted R3 to eat breakfast at the kitchen table in her apartment. On February 12, 2025, at 10:47 a.m., ULP-I stated R3 went to the dining room for lunch and dinner, but liked to eat breakfast in her apartment. ULP-I stated R3 would participate in a once-monthly communal breakfast in the dining room. ULP-I further stated she had not documented R3's refusal to eat meals in the dining area. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated June 8, 2023, indicated the licensee's available services included manual feeding, but did not include: -feeding in resident's apartment with one staff member per resident; -meal preparation in resident unit; or -feeding in a common area with one staff member per resident. On February 12, 2025, at 12:06 p.m., registered nurse (RN)-C stated she was unaware R3 had been fed breakfast in her apartment, on a daily basis, by ULPs. RN-C further stated there had	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30754	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LAKES SENIOR LIVING LLC	12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369

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02320	Continued From page 30 been no documentation from the ULPs indicating R3 was being fed breakfast in her apartment. The licensee's Service Plan policy dated August 1, 2021, indicated service plans would be based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02320		

Minnesota Department of Health

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

Type: Full
Date: *02/12/25*
Time: 16:00:00
Report: 8087251013

Food and Beverage Establishment Inspection Report

Location:

Arbor Lakes Senior Living Llc
12001 80th Avenue North
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:

ID #: 0037515
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635757021
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

Wash Temperature Gauge: = -- at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 181 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 169 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 6 Degrees Fahrenheit - Location: REACH-IN FREEZER - MEMORY CARE WEST
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE WEST
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE WEST
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE WEST
Violation Issued: No

Process/Item: Ambient Air
Temperature: 1 Degrees Fahrenheit - Location: REACH-IN FREEZER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Ambient Air
Temperature: 32 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 33 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Cold Holding: EGGS
Temperature: 32 Degrees Fahrenheit - Location: STAND-UP COOLER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: BEVERAGE COOLER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Hot Holding: SOUP
Temperature: 141 Degrees Fahrenheit - Location: SOUP WARMER - MEMORY CARE EAST
Violation Issued: No

Process/Item: Ambient Air
Temperature: -23 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

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

Process/Item: Cold Holding: SOUP
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: COOKED PASTA
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Air
Temperature: -3 Degrees Fahrenheit - Location: PREP LINE FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: PREP LINE REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 35 Degrees Fahrenheit - Location: PREP LINE REACH-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: EXPO REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 33 Degrees Fahrenheit - Location: EXPO REACH-IN COOLER
Violation Issued: No

Process/Item: Hot Holding: CHICKEN
Temperature: 179 Degrees Fahrenheit - Location: SERVICE LINE WARMING UNIT
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH EXECUTIVE CHEF JOHN TORMOEN.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO NURSE SURVEYOR RHONDA MAKELA.

Type: Full
Date: *02/12/25*
Time: 16:00:00
Report: 8087251013
Arbor Lakes Senior Living Llc

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 8087251013 of 02/12/25.

Certified Food Protection Manager: DENNIS FERGUSON

Certification Number: FM3226 Expires: 10/26/28

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOHN TORMOEN
EXECUTIVE CHEF

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