Electronically Delivered

March 29, 2023

Licensee
Silvercrest Properties LLC
16880 Klamath Trail
Lakeville, MN 55044

RE: Project Number(s) SL29470015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 9, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

correction order receipt date.

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

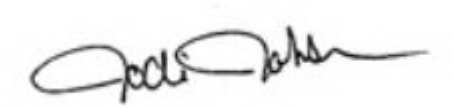
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29470	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	16880 KLAMATH TRAIL LAKEVILLE, MN 55044

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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: SL29470015 On March 6, 2023, through March 9, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 99 active residents; 67 of whome were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all	0 620		

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0 620	Continued From page 2 cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R9, R8). 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: R9 R9's diagnosis included hypertension (high blood pressure). R9's Service Plan (Private) - Addendum to Contract effective February 10, 2023, indicated the resident received services including medication administration, bathing assistance, dressing, grooming, and incontinence care. R9's Individual Abuse Prevention Plan dated January 17, 2023, identified the resident was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually). Specific interventions to minimize this risk included for staff to monitor for signs or symptoms of abuse/neglect/exploitation and report to nurse promptly. The assessment failed to address the	0 620		

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0 620	Continued From page 3 resident's risk of abusing other vulnerable adults. A MAARC report submitted February 6, 2023, at 7:42 p.m. indicated on February 4, 2023, at 8:00 a.m. registered nurse (RN)-L witnessed an interaction between a family member and R9 while in R9's apartment. R9 was experiencing paranoia that she was being held hostage and needed to go to the bank to withdraw money for her ransom. The family member was encouraging R9's paranoia and was observed going through R9's drawers attempting to find credit cards. The family member was quoted as saying "we will need three forms of ID to do anything at the bank". The report identified RN-L was concerned the family member was attempting to take R9 out of the community to gain access to her money. The MAARC report was submitted more than 59 hours later. On March 8, 2023, at 9:11 a.m. licensed assisted living director in residence (LALDIR)-A stated RN-L had not notified her until February 6, 2023, of the witnessed event. LALDIR-A stated only herself and RN-B do MAARC reporting. LALDIR-A further stated all staff were trained yearly on vulnerable adult reporting requirements and RN-L should have reported to LALDIR-A immediately so a report could have been filed timely. LALDIR-A verified the MAARC report was filed late. R8 R8's diagnosis included Alzheimer's disease. R8's Service Plan (Private) - Addendum to Contract effective September 13, 2022, indicated the resident received services including medication administration and blood pressure checks monthly.	0 620		

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0 620	Continued From page 4 R8's Individual Abuse Prevention Plan dated January 24, 2023, identified the resident was not at risk to be abused. The assessment failed to address the resident's risk of abusing other vulnerable adults. A MAARC report submitted September 29, 2022, at 9:26 a.m., indicated on September 27, 2022, at 2:00 p.m. R8 had signed a notice to vacate the community and would be moved out of the community by October 31, 2022. The report identified R8 stated he did not have a plan for where he would live after the vacate date and did not have full access to his bank accounts. The report further identified R8 was working with his lawyer to gain access to his funds after an expiration of emergency guardianship from his children on August 26, 2022. The MAARC report was submitted 43 hours later. On March 8, 2023, at 9:11 a.m. licensed assistant living director in residence (LALDIR)-A stated the MAARC report was not filed right away and should have been. LALDIR-A indicated R8 had made statements that he was moving out and then say he wasn't. LALDIR-A indicated she wanted it to be "definite" before reporting it. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy revised October 4, 2022, indicated: 5. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will: d. contact the executive director f. if the executive director or clinical director confirms the suspicion of maltreatment, they will	0 620		

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0 620	Continued From page 5 contact MAARC. Such report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	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 interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for four of five residents (R3, R2, R4, and R6). 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 pattern scope (when more than a	0 630		

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0 630	Continued From page 6 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: R3 R3's diagnoses included dementia and arthritis. R3's Service Plan (Private) - Addendum to Contract effective February 22, 2023, indicated R3 resided in the memory care community and received services which included bathing, dressing, toileting, and medication administration. R3's Individual Abuse Prevention Plan (IAPP) dated February 23, 2023, noted R3 was not at risk to be abused and was not at risk to abuse other vulnerable adults. On March 7, 2023, at 11:08 a.m. registered nurse (RN)-B stated R3 resides in the memory care community and is vulnerable to abuse by others. RN-B indicated R3's IAPP was not accurate and therefore lacked statements of specific measures to be taken to minimize the risk of abuse to that person. R2 R2's diagnosis included atrial fibrillation (abnormal heart rhythm). R2's Service Plan (Private) - Addendum to Contract effective February 15, 2023, indicated R2 resided in the memory care community and received services which included medication administration, and memory care level 3. R2's Individual Abuse Prevention Plan dated	0 630		

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0 630	Continued From page 7 February 14, 2023, noted resident had areas of vulnerability and was susceptible to abuse by another individual with statements of specific measures to be taken to minimize the risk of abuse. However, the assessment lacked an individualized review or assessment of the person's risk of abusing other vulnerable adults. R4 R4's diagnosis included atrial fibrillation, and hypertension (high blood pressure). R4's Service Plan (Private) - Addendum to Contract effective November 4, 2022, indicated R4 resided in assisted living and received services which included assistance with bathing and medication administration. R4's Individual Abuse Prevention Plan dated February 15, 2023, noted resident had areas of vulnerability and was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually) by another individual with statements of specific measures to be taken to minimize the risk of abuse. However, the assessment lacked an individualized review or assessment of the person's risk of abusing other vulnerable adults. R6 R6's diagnosis included diabetes, major depressive disorder, and hypertension. R6's Service Plan (Private) - Addendum to Contract effective July 28, 2022, indicated R6 resided in the enhanced assisted living community and received services which included bathing, dressing, and medication administration. R6's Individual Abuse Prevention Plan dated	0 630		

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0 630	Continued From page 8 January 10, 2023, noted resident had areas of vulnerability and was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually) by another individual with statements of specific measures to be taken to minimize the risk of abuse. However, the assessment lacked an individualized review or assessment of the person's risk of abusing other vulnerable adults. On March 9, 2023, at 8:20 a.m. RN-B stated the assessments for R2, R4, and R6 did not specifically address the person's risk of abusing other vulnerable adults and the assessments would need to be updated. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy revised October 4, 2022, identified [The Licensee] would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 9 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for	01060		

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01060	Continued From page 10 three of three residents (R2, R4, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 R2 began receiving assisted living services on February 16, 2023. R2's Service Plan (Private) - Addendum to Contract effective February 15, 2023, indicated R2 resided in the memory care community and received services which included medication administration, and memory care level 3. R2's Residents Notes dated February 21, 2023, at 8:30 p.m. indicated R2 was found on the floor next to his bed and was transported to the hospital for evaluation. Resident Notes dated February 25, 2023, at 2:33 p.m. identified R2 returned from the hospital (four days later). R4 R4 began receiving assisted living services on June 24, 2017. R4's Service Plan (Private) - Addendum to Contract effective November 4, 2022, indicated R4 resided in assisted living and received services which included assistance with bathing and medication administration.	01060		

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01060	Continued From page 11 R4's Residents Notes dated December 23, 2022, at 9:49 p.m. indicated R4 was admitted to the hospital on December 16, 2022, and returned on December 20, 2022, with medication changes (four days later). R2 and R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On March 8, 2023, at 3:30 p.m. licensed assisted living director in residence (LALDIR)-A stated no written notice was provided to R2 or R4. LALDIR-A stated she had misunderstood the regulation and thought the notice only needed to be completed after a resident had not returned in four days and would complete simultaneously with notification to the Office of Ombudsman for Long-Term Care. R3 R3 began receiving assisted living services on March 8, 2022. R3's Service Plan (Private) - Addendum to	01060		

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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
01060	Continued From page 12 Contract effective February 22, 2023, indicated R3 resided in the memory care community and received services which included bathing, dressing, toileting and medication administration. R3's Incident Report dated February 12, 2023, at 11:35 p.m. identified 911 was called and R3 was transferred to hospital after being found on the bathroom floor. Subsequent documentation identified R3 had been admitted to the hospital with a right hip fracture on February 13, 2023. R3's Clinical Update Assessment (identified as a hospital return assessment) dated February 23, 2023, indicated R3 returned to the assisted living facility on February 23, 2023. (11 days later) The Office of Ombudsman for Long-Term Care had been notified and a written notice was provided to R3 and the designated representative on February 15, 2023; however, the notice lacked a written notice that contained, at a minimum: - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On March 7, 2023, at 2:46 p.m. LALDIR-A verified the facility's form lacked the required notice as noted above. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, included: 1. In the event of an emergency relocation, the community staff will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the	01060		

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	29470	A. BUILDING: _____ B. WING _____	03/09/2023

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01060	Continued From page 13 location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01620 SS=D	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	01620		

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01620	Continued From page 14 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment after a return from the hospital for one of one resident (R4). In addition, the RN failed to complete a 14-day assessment timely for one of one resident (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, 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: R4 R4's started receiving services June 24, 2017,	01620		

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01620	Continued From page 15 with a diagnosis including atrial fibrillation (abnormal heart rhythm) and hypertension (high blood pressure). R4's Service Plan (Private) - Addendum to Contract effective November 4, 2022, indicated R4 resided in assisted living facility and received services which included assistance with bathing and medication administration. R4's residents notes dated December 23, 2022, at 9:49 p.m. indicated R4 was admitted to the hospital on December 16, 2022, and returned to the assisted living facility on December 20, 2022, with medication changes. R4's record indicated clinical update assessments by the RN had completion dates as follows: November 15, 2022, labeled as a 14-day assessment February 15, 2023, labeled as a 90-day assessment March 7, 2023, labeled as a hospital return (after the start of the survey and 77 days after return from the hospital) On March 7, 2023, at 1:00 p.m. RN-B confirmed R4's files did not contain a change in condition assessment after R4's return from the hospital. R2 R2 started receiving assisted living services February 16, 2023. R2's Service Plan (Private) - Addendum to Contract effective February 15, 2023, indicated R2 resided in the memory care community and received services which included medication administration, and memory care level 3.	01620		

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01620	Continued From page 16 R2's assessments were requested. R2's initial assessment was dated February 14, 2023, and his 14-day assessment was dated March 7, 2023 (21 days after R2's start of services). On March 8, 2023, at 4:10 p.m. RN-B verified R2's 14-day assessment was completed late. RN-B indicated R2 had been hospitalized February 21, 2023, through February 25, 2023, but did not have any change of condition so no new assessment had been completed. RN-B stated she thought the 14-day assessment would start following the return from hospital. The licensee's 6.01 Assessments, Review & Monitoring policy dated August 1, 2021, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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01750	Continued From page 17 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for one of five resident (R3) who received medication administration. 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 diagnoses included dysphagia (difficulty swallowing), dementia (memory loss), hypertension (high blood pressure), and arthritis. R3's Service Plan (Private) - Addendum to Contract effective February 22, 2023, indicated R3 resided in the memory care community and received medication administration. R3's most recent prescriber orders dated February 20, 2023, did not include an order to crush medications.	01750		

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01750	Continued From page 18 On March 7, 2023, at 9:16 a.m. unlicensed personnel (ULP)-E was observed to prepare and administer R3's scheduled morning medication. ULP-E placed the prescribed medication into a medication cup and handed to R3. R3 took the medication with a drink of water. R3's Clinical Update Assessment titled "Hospital Return" dated February 23,2023, included R3's Medication Management Plan. The plan identified R3 required full assist with medications by unlicensed staff. The plan further identified a risk due to complex medication regimen (i.e., cut or crush tables, frequency of meds given, specific instructions on how the med must be given): yes, medications to be crushed. On March 8, 2022, at 11:00 a.m. ULP-E stated she would crush R3's medications when she gets more than one pill, "like at noon", but would not crush the morning medication since it is only one pill. ULP-E stated R3's medication administration record (MAR) did not direct the medications to be crushed, but stated she worked a lot and "knows the resident". On March 8, 2023, at 2:10 p.m. RN-B stated she should obtain an order from the physician to crush a resident's medications and ULP should not be determining when and what medications should be crushed. RN-B confirmed R3's record lacked specific written instructions identifying what medications should be crushed. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of medications is delegated to ULP, the licensee will ensure that the registered nurse has: specified, in writing, specific instructions for each resident	01750		

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01750	Continued From page 19 and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents' (R7, R6) insulins were stored securely and according to the manufacturer's recommendations. 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: R7 R7 began receiving assisted living services December 31, 2021.	01880		

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01880	Continued From page 20 R7's diagnosis included diabetes and dementia. R7's Clinical Update Assessment identified as a 90-day assessment dated January 19, 2023, included a medication management plan and identified R7's medications were stored in a locked medication cart. The assessment further identified R7 was unable to give herself medication related to her memory impairment, and unlicensed staff would be responsible for administering medications. R7's Service Plan (Private) - Addendum to Contract effective date February 7, 2023, indicated R7 received services including medication administration. On March 7, 2023, at 8:31 a.m. unlicensed personnel (ULP)-E was observed to obtain an insulin pen needle from the medication cart and enter R7's room. ULP-E stated each resident's insulin was stored in their individual refrigerators within their apartments. ULP-E obtained R7's NovoLog (a fast-acting insulin) FlexPen 70/30 from the resident's refrigerator. ULP-E washed her hands, applied gloves, used an alcohol swab to cleanse the end of the insulin pen and applied the new needle. ULP-E then wasted two (2) units, dialed it to the prescribed 20 units and administered the insulin after cleansing the skin to R7's right upper quadrant. Following the insulin administration, ULP-E removed the needle and placed it into the sharps container. ULP-E removed her gloves, washed her hands, and then placed the NovoLog FlexPen 70/30 back into R7's refrigerator. R6 R6's diagnosis included diabetes, major	01880		

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01880	Continued From page 21 depressive disorder, and hypertension. R6's latest comprehensive nursing assessment, identified as a 90-day assessment dated January 10, 2023, indicated R6 needed assistance with taking medications including insulin. The assessment further indicated there was secure storage of all medications and interventions in place to prevent the diversion of medication by locking in a medication cart. R6's Service Plan (Private) - Addendum to Contract effective July 28, 2022, indicated R6 resided in the enhanced assisted living community and received services which included bathing, dressing, and medication administration. On March 7, 2023, at 9:15 a.m. ULP-H was observed reviewing R6's electronic medical record (EMAR) for the sliding scale insulin dose. ULP-H opened the resident's apartment refrigerator to take out Lispro (a fast-acting insulin) Kwik pen and drew up the required units according to the sliding scale. Once completed, ULP-H replaced R6's insulin pen back in the refrigerator. On March 7, 2023, at 3:52 p.m. registered nurse (RN)-B stated all insulin pens were kept in the individual refrigerators of each resident. RN-B further indicated medications should be secured and stored per manufacturer instructions. NovoLog Mix 70/30 FlexPen Patient Information and Instructions for use revised March 2021, included: store the FlexPen you are currently using (opened) at room temperature below 86 degrees Fahrenheit (F) for up to 14 days (do not refrigerate).	01880		

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01880	Continued From page 22 The manufacturer instructions for Humalog (lispro) dated March 2013, indicated in section 16.2 storage and handling, In-use Kwik pens should be stored at room temperature. . The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be stored per manufacturer's directions. In addition, the policy identified medications would be stored consistent with each residents' medication management plan and service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	02170		

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02170	Continued From page 23 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for one of two residents (R2) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	02170		

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02170	Continued From page 24 The licensee held an assisted living with dementia care license, effective August 1, 2022. R2's diagnosis included atrial fibrillation (abnormal heart rhythm). R2's Service Plan (Private) - Addendum to Contract effective February 15, 2023, indicated R2 resided in the memory care community and received services which included medication administration, and memory care level 3. On March 7, 2023, at 8:58 a.m. unlicensed personnel (ULP)-M was observed pushing R2 in a wheelchair into the dining room for breakfast. R2's record contained an Individualized Activity Plan undated, that identified R2 required assistance to walk and depended on staff for routine escorts, needed daily reminders to attend activities, required help with bilateral hearing aids and reminders and assistance to wear and clean glasses; however, R2's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's records did not include evidence of an individualized activity plan based on the resident's activity assessment. On March 8, 2023, at 3:45 p.m. licensed assisted living director in residence (LALDIR)-A stated R2's record was lacking an activity assessment	02170		

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02170	Continued From page 25 with the required components. The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy revised July 19, 2022, included: 2. Each resident is evaluated for activities according to the licensing rules of the facility. In addition, the resident care plan addresses the following: -past and current interests -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behaviors interventions 3. An individual activity plan is developed for each resident based on their activity evaluation. The plan reflects the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the	03000		

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03000	Continued From page 26 individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29470	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	16880 KLAMATH TRAIL LAKEVILLE, MN 55044

(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
03000	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R9, R8). 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: R9 R9's diagnosis included hypertension (high blood pressure). R9's Service Plan (Private) - Addendum to Contract effective February 10, 2023, indicated the resident received services including medication administration, bathing assistance, dressing, grooming, and incontinence care. R9's Individual Abuse Prevention Plan dated January 17, 2023, identified the resident was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually). Specific interventions to minimize this risk included for staff to monitor for signs or symptoms of abuse/neglect/exploitation and report to nurse promptly. The assessment failed to address the resident's risk of abusing other vulnerable adults.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29470	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	16880 KLAMATH TRAIL LAKEVILLE, MN 55044

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03000	Continued From page 28 A MAARC report submitted February 6, 2023, at 7:42 p.m. indicated on February 4, 2023, at 8:00 a.m. registered nurse (RN)-L witnessed an interaction between a family member and R9 while in R9's apartment. R9 was experiencing paranoia that she was being held hostage and needed to go to the bank to withdraw money for her ransom. The family member was encouraging R9's paranoia and was observed going through R9's drawers attempting to find credit cards. The family member was quoted as saying "we will need three forms of ID to do anything at the bank". The report identified RN-L was concerned the family member was attempting to take R9 out of the community to gain access to her money. The MAARC report was submitted more than 59 hours later. On March 8, 2023, at 9:11 a.m. licensed assisted living director in residence (LALDIR)-A stated RN-L had not notified her until February 6, 2023, of the witnessed event. LALDIR-A stated only herself and RN-B do MAARC reporting. LALDIR-A further stated all staff are trained yearly on vulnerable adult reporting requirements and RN-L should have reported to LALDIR-A immediately so a report could have been filed timely. LALDIR-A verified the MAARC report was filed late. R8 R8's diagnosis included Alzheimer's disease. R8's Service Plan (Private) - Addendum to Contract effective September 13, 2022, indicated the resident received services including medication administration and blood pressure checks monthly.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29470	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 29 R8's Individual Abuse Prevention Plan dated January 24, 2023, identified the resident was not at risk to be abused. The assessment failed to address the resident's risk of abusing other vulnerable adults. A MAARC report submitted September 29, 2022, at 9:26 a.m., indicated on September 27, 2022, at 2:00 p.m. R8 had signed a notice to vacate the community and would be moved out of the community by October 31, 2022. The report identified R8 stated he did not have a plan for where he would live after the vacate date and did not have full access to his bank accounts. The report further identified R8 was working with his lawyer to gain access to his funds after an expiration of emergency guardianship from his children on August 26, 2022. The MAARC report was submitted 43 hours later. On March 8, 2023, at 9:11 a.m. licensed assistant living director in residence (LALDIR)-A stated the MAARC report was not filed right away and should have been. LALDIR-A indicated R8 had made statements that he was moving out and then say he wasn't. LALDIR-A indicated she wanted it to be "definite" before reporting it. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy revised October 4, 2022, indicated: 5. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained will: d. contact the executive director f. if the executive director or clinical director confirms the suspicion of maltreatment, they will contact MAARC. Such report must be made no	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 30 later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/07/23*
Time: 10:00:40
Report: 1024231036

Food and Beverage Establishment Inspection Report

Location:
Silvercrest Properties Llc
16880 Klamath Trail
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0037972
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9524354018
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.

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

SANI BUCKET MEASURED 100 PPM. DIRECTOR CHANGED SOLUTION ON SITE.

Corrected on Site

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

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

OBSERVED ICE SCOOP HANDLE TOUCHING ICE ON MAIN LINE. DIRECTOR REMOVED SCOOP SO HANDLE WOULD NOT TOUCH ICE.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO HANDWASHING SIGN AT HANDWASHING SINK OF REFLECTIONS AREA. KITCHEN MANAGER PROVIDED SIGN ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonium: = 100 PPM at Degrees Fahrenheit
Location: SANI BUCKET - MAIN LINE
Violation Issued: Yes

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: LOWER PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/MILK
Temperature: 40 Degrees Fahrenheit - Location: STAND UP COOLER
Violation Issued: No

Process/Item: Hot Holding/SOUP
Temperature: 171 Degrees Fahrenheit - Location: APW WYOTT WARMER
Violation Issued: No

Process/Item: Cooling/CUT MELON
Temperature: 47 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Holding/TILAPIA
Temperature: 166 Degrees Fahrenheit - Location: WARMING CABINET
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 41 Degrees Fahrenheit - Location: COOLER - REFLECTIONS AREA
Violation Issued: No

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

DISCUSSED ALL ORDERS WITH HRD NURSING EVALUATORS SUSAN KALIS AND TRACEY FEARON. DISCUSSED WITH KITCHEN MANAGER JOE WASHBURN AND CORPORATE DINING DIRECTOR, STEVE CAMERON ALL ORDERS IN ADDITION TO THE FOLLOWING ON SITE.

- ALL ORDERS ON REPORT.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.

- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING.
- PROPER SANITIZING LEVELS AND TEST KITS AND STRIPS ON SITE.
- PEST CONTROL.

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 1024231036 of 03/07/23.

Certified Food Protection Manager: JEFFREY JOSEPH WASHBURN

Certification Number: FM108142 Expires: 10/24/24

Signed: _____

JOE WASHBURN
KITCHEN MANAGER

Signed: 

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us