Electronically Delivered

June 2, 2023

Licensee
Johanna Shores
3200 Lake Johanna Boulevard
Arden Hills, MN 55112

RE: Project Number(s) SL20113015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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).

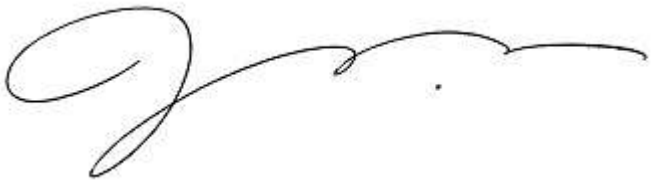
Please address your cover letter for reconsideration requests to:

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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-247-0268 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20113	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHANNA SHORES	3200 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20113015-0 On May 15, 2023, through May 17, 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 98 active residents; all 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the 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 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated May 15, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 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 hand hygiene for one of two unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 16, 2023, at 8:30 a.m., the surveyor observed ULP-F wash hands and set up R7's medications within R7's apartment. ULP-F washed hands again and donned (applied) gloves and handed the medications to R7 to self-administer. ULP-F set up the supplies to check R7's blood sugar. Once completed, ULP-F	0 510		

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0 510	Continued From page 3 opened a container of R7's triamcinolone lotion and applied to R7's back with the same gloves used for the blood sugar check. ULP-F then doffed (removed) gloves and replaced the cap on the lotion container and returned supplies in kitchen. ULP-F used the keys to lock the cabinet and document on the iPad. When exited, ULP-F washed hands. Surveyor did observe a small bottle of hand sanitizer attached to ULP-F's fanny pack. During interview on May 16, 2023, at 9:20 a.m., surveyor asked ULP-F when he/she was trained to remove gloves and perform hand hygiene. ULP-F stated, "I wash my hands before and after cares and if I remove my gloves, I do wash my hands." The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. During interview on May 16, 2023, at 2:40 p.m., director of nursing (DON)-A indicated it was expected gloves be removed right after the task and hands washed before next task. The licensee's undated Infection Prevention and Control Manual-Glove Technique (Non-Sterile) policy indicated staff would don clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Additionally, staff would remove gloves promptly after use, before touching non-contaminated items and	0 510		

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0 510	Continued From page 4 environmental surfaces. Perform hand hygiene after removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 800		

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0 800	Continued From page 5 Findings include: On facility tour with the Environmental Services Director (ESD)-I between approximately 1:00 PM and 3:30 PM on May 16, 2023, it was observed that the trash chute door on the third floor was broken and unable to close and positively latch as required as part of the fire rated shaft assembly. This deficient condition was visually verified by ESD-I accompanying on the tour. Additionally, while on tour, it was noted that within the second-floor memory care serving kitchen, gates (2) and counter drawers with utensils were unsecured and able to be easily accessed. This deficient condition was visually verified by ESD-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 6 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 7 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two unlicensed personnel ((ULP)-B). In addition, the licensee failed to include the required training topics for the annual training. 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: ULP-B was hired on January 10, 2022, and was observed providing direct care services to residents on May 16, at 8:17 a.m. ULP-B's employee record contained training documents and a Relias (online training platform) transcript. ULP-B's record lacked the "PHS" annual training module provided through Relias. ULP-B's record lacked the following annual training: -Assisted Living Bill of Rights; -review of provider policies and procedures; -principles of person-centered planning/service delivery; and -documentation of required annual training hours. On May 16, 2023, at 2:30 p.m., director of nursing	01500		

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01500	Continued From page 8 (DON)-A stated they used Relias for their annual training, the training module was called, "2023 PHS Annual Training," and included the required annual training content. On May 17, 2023, at 10:01 a.m., human resource manager (HRM)-E indicated via email, "[ULP-B]'s annual training (2023 annual training) is showing that it is not due until 1/10/2024 in Relias, so it is assigned to her, but not yet completed. Our policy is that the annual training is assigned and completed 1x/year, typically due within the employee's anniversary month. She was educated on all of this content at the time of hire, but her PHS Annual Training is not showing due until 1/10/2024 (available to start completing 12/11/2023)." Further at 10:54 a.m., HRM-F's email indicated, "It looks like all of [ULP-B]'s other annual courses populated correctly and were completed, but this one didn't get assigned and was not completed because it wasn't showing as due. We've reached out to our Relias SME [subject matter expert] to determine why that one course populated with different dates, the answer is pending." The licensee's Required Training Guide dated May 9, 2023, indicated the following annual training required for their ULP staff: "- PHS Annual Training (Auto Enrolled) (1.5) - N95 Fit Testing & Medical Evaluation-with Clin Admin - Observing & Reporting - Assisted Living Home Health Aide (Annual) (Auto Enrolled) (.5) -Annual AL RA Skills/Medication Competency Evaluation (MN & W WI Only) (Auto Enrolled) -Annual AL RA Skills/Medication Competency Evaluation (8) (MN & WI) Class needs registration into specific session -Annual AL RA Skills/Medication Competency	01500		

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01500	Continued From page 9 Checklist -Using Oxygen Safely Self-Paced (.25) -The Dining Experience (.75) -Assisting with Personal Care (1.) (W WI Only)" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff completed the required eight (8) hours of dementia care training within eighty (80) hours of hire for one of four employees (licensed practical	01540		

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01540	Continued From page 10 nurse (LPN)-C). 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: The licensee had a current assisted living facility with dementia care license. LPN-C was re-hired to provide services for licensee on August 29, 2021. LPN-C's Relias Transcript (online training platform) indicated 1.5 hours of dementia training was completed upon re-hire and included any dementia training hours within 18 months from previous employment. LPN-C's RN/LPN Orientation Checklist Assisted Living record dated January 12, 2022, indicated LPN-C completed additional four hours of dementia training which was 137 days from date of hire. LPN-C's employee record lacked documentation that eight (8) hours of dementia training was completed. During interview on May 16, 2023, at 2:40 p.m., director of nursing (DON)-A indicated there was a system glitch with Relias which didn't auto-enroll the dementia courses for LPN-C. DON-A stated	01540		

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01540	Continued From page 11 he/she went on leave in September of 2021 and follow up on the training wasn't completed until January 12, 2022, when he/she returned. The licensee's Dementia Training Policy dated August 1, 2021, indicated the licensee provided specialized training in the area of Alzheimer's Disease and Related Disorders to its employees that also meet regulatory requirements and timelines. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R3) with bed rails. 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	02310		

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	20113	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHANNA SHORES	3200 LAKE JOHANNA BOULEVARD ARDEN HILLS, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 12	02310		

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 May 16, 2023, indicated R3 received services for extensive assistance in morning and evening (AM, PM), homemaking, laundry, and bathroom assist six times or more per day.

R3's record lacked any documentation of a hospital bed or bed rail being in use.

The licensee's Client Roster dated May 15, 2023, indicated R3 did not have bed rails.

On May 16, 2023, at 8:38 a.m., unlicensed personnel (ULP)-B was observed providing cares to R3. Surveyor observed R3 in their hospital bed with two (2) bed rails, surveyor pulled on the bed rails which was firmly attached to the hospital bed. R3 had 2 daughters present at the time of observation and both stated R3 was recently put on hospice through the licensee's hospice company. The daughters stated R3's hospital bed was delivered over the past weekend (two or three days ago) and were unsure if nursing staff were aware of its presence or the bed rails. The daughters stated R3 had five (5) children and they were staying with R3 until she passed away.

On May 16, 2023, at 9:01 a.m., surveyor sent an email to the director of nursing (DON)-A and licensed assisted living director (LALD)-D requesting R3's bed rail assessment.

On May 16, 2023, at 9:55 a.m., DON-A and LALD-D stated R3 had recently begun receiving

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	20113	A. BUILDING: _____ B. WING _____	05/17/2023

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02310	Continued From page 13	02310		

hospice care services. DON-A stated the hospice company had the hospital bed delivered over the weekend on May 13, 2023, without their knowledge. DON-A stated the bed rails should have been brought to the nursing staff's attention immediately by either hospice or their own ULP staff. DON-A stated the family was at the facility 24 hours per day seven (7) days a week since R3 being put on hospice and had taken over providing the majority of R3's cares and medication administration. They stated an all-staff training for direct-care staff was initiated immediately after the surveyor brought the bed rail to their attention. The education would include their bed rail policy and notifying nursing when new bed rails were discovered. DON-A stated R3 was assessed immediately after the surveyor requested R3's bed rail assessment. It was determined bed rails were not appropriate for R3 due to her continued cognitive and physical decline related to end of life transition, the bed rails were removed.

On May 16, 2023, at approximately 10:30 a.m., observed R3's hospital bed and the bed rails were no longer on the bed.

The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to

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02310	Continued From page 14 determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) last update April 25, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	02310		

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02310	Continued From page 15 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Physical Device policy dated June 2018, indicated: "1. The use of any physical device will be reviewed and discussed at or prior to the start of home care, with each clinical review and with the initiation of a new device when facility is made aware. 2. As indicated in the Resident Bill of Rights, residents and/or the resident responsible parties have the ability to choose the equipment and furnishings in their apartment, as defined in the resident lease agreement. [Licensee] and Services Homecare will partner with the resident to determine recommended devices that support the resident's independence and physical functioning. The device will be recommended for use based on the manufacturer's recommendations. It is to be noted that [Licensee] and Services Homecare may not be made aware or identify that a physical device has been initiated if the resident elects to add the device without consultation or partnership with the homecare agency. In an effort to support collaboration, an education resource on safety and physical device use will be provided upon admission to each home care client.	02310		

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02310	Continued From page 16 3. The resident care plan and vulnerability assessment will be updated to reflect the device to be used. 4. Informed consent for the physical device will be completed by the resident or responsible party. Telephone consent may be obtained when unable to meet with the responsible party. Documentation of the telephone consent will be completed in the form of a clinical note in the resident's medical chart. A copy of the informed consent will be placed in the chart until the original signed consent is returned. 5. [Licensee] and Services Homecare staff will document in the resident's clinical record at the implementation of the device or upon identification of the device by the homecare staff. 6. With changes in condition, the resident's functional use of the device will be assessed. Any changes with the use of the device should be reflected in the resident's care plan and vulnerability assessment. 7. [Licensee] and Services engineering staff will assist residents with the installation on bed assistive devices (that meet FDA requirements) on personal beds only under the following guidelines: a. The resident has been assessed as above for the appropriate use of the device. b. The resident and/or responsible party have agreed to the use and installation of the device as intended per manufacturer's recommendations c. The resident and/or responsible party has agreed to pay for the installation and maintenance of the device by the engineering staff d. The manufacturer's guidelines have been provided to [Licensee] and Services Homecare and engineering staff e. And when installed device and bed meet	02310		

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02310	Continued From page 17 FDA requirements for zones of entrapment 8. [Licensee] and Services will make available to the resident a list of recommended assistive devices which would meet the FDA requirements for bed safety. The devices will be easily available for independent purchase through a third party vendor. 9. [Licensee] and Services therapists and [hospice] therapists are made aware of these products for referral and purchase. Contracted therapy can be considered for a home safety assessment to make recommendations with a physician's order. 10. For the purposes of bed assist devices - staff will get a physician's order. 11. Devices that are requested, which are not recommended, and are not FDA approved, will NOT be allowed at [Licensee] and Services." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *05/15/23*
Time: 13:52:25
Report: 1021231132

Food and Beverage Establishment Inspection Report

Location:
Johanna Shores
3200 Lake Johanna Boulevard
Arden Hills, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0038269
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6516316070
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.

2-300 Personal Cleanliness

2-301.15 ** Priority 2 **

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

STAFF WORKING AT THE BISTRO WAS OBSERVED WASHING THEIR HANDS IN THE DUMP SINK. DISCUSSED WITH DIRECTOR THAT STAFF NEED TO WASH THEIR HANDS IN THE HANDWASHING SINK. DIRECTOR HAD A CONVERSATION WITH STAFF DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 05/15/23

Surface and Equipment Sanitizers

Sink & Surface Sanitizer: = 272PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET, MEMORY CARE
Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET, BISTRO
Violation Issued: No

Final Utensil Surface Temp: = at 167 Degrees Fahrenheit
Location: DOWNSTAIRS DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 171 Degrees Fahrenheit - Location: CAULIFLOWER SOUP - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: GRAVY - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 170 Degrees Fahrenheit - Location: POTATOES - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - TRAULSEN TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: PUDDING - TRAULSEN TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CUT TOMATO - TRAULSEN UPRIGHT COOLER, MEMORY CARE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - TRAULSEN UPRIGHT COOLER, MEMORY CARE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 178 Degrees Fahrenheit - Location: CAULIFLOWER SOUP - HOT WELLS, BISTRO
Violation Issued: No

Process/Item: Hot Holding
Temperature: 159 Degrees Fahrenheit - Location: PORK - HOT WELLS, BISTRO
Violation Issued: No

Process/Item: Hot Holding
Temperature: 171 Degrees Fahrenheit - Location: POTATOES - HOT WELLS, BISTRO
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: BEEF SANDWICH - DISPLAY COOLER, BISTRO
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: HOUSE SALAD - GRAB N GO COOLER, BISTRO
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: PUDDING - GRAB N GO COOLER, BISTRO
Violation Issued: No

Type: Full
Date: *05/15/23*
Time: 13:52:25
Report: 1021231132
Johanna Shores

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - UNDER COUNTER COOLER, BISTRO
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH CULINARY DIRECTOR, KRISTI SALISBURY, AND HEALTH REGULATION DIVISION NURSE EVALUATORS, ANNA BOHNEN AND JOEY KEEN.

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 1021231132 of 05/15/23.

Certified Food Protection Manager: MARY J. KLUTHE

Certification Number: FM24889 Expires: 04/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
KRISTI SALISBURY
CULINARY DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us