DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 15, 2023

Licensee
The Centennial House Apple Valley
14625 Pennock Avenue
Apple Valley, MN 55124

RE: Project Number(s) SL20316015

Dear Licensee:

On May 12, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Electronically Delivered

April 18, 2023

Licensee
The Centennial House Apple Valley
14625 Pennock Avenue
Apple Valley, MN 55124

RE: Project Number(s) SL20316015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a surveyon March 23, 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the MDH imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH imposes a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,500. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance withMinn. 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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 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
	20316	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTENNIAL HOUSE APPLE VAL	14625 PENNOCK AVENUE APPLE VALLEY, MN 55124

(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: SL20316015 On March 20, 2023, through March 23, 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 58 active residents: all of whom were receiving services under the Assisted Living/ Dementia Care license. 2310: An immediate correction order was issued on March 21, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I).	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). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	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 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	0 510		

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0 510	Continued From page 2 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 complies with accepted health care, medical and nursing standards related to glove use and handwashing during treatment and medication administration by five of five unlicensed personnel (ULP-G, ULP-E, ULP-J, ULP-I, ULP-K). This had the potential to affect all 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility had two medication rooms; each with a wall hand sanitizer unit secured at the doorway and also a portable hand sanitizer sitting on the shelf within each room. ULP-G On March 21, 2023, at 7:20 a.m. ULP-G was observed to administer medication to a resident, returned to the medication cart and removed gloves, but failed to wash/sanitize their hands before putting on new gloves and setting up	0 510		

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0 510	Continued From page 3 medications for the next resident. ULP-E On March 21, 2023, at 8:30 a.m. the surveyor observed ULP-E administering medications to residents and changing gloves between each one, but failed to sanitize their hands when changing their gloves. On March 22, 2023, at 12:30 p.m. registered nurse (RN)-F and RN-L indicated they had spent a lot of time training staff on infection control standards, and the expectation is that they would wash or sanitize their hands between donning and doffing gloves. ULP-J On March 21, 2023, at 7:30 a.m. the surveyor observed ULP-J put on gloves, assist R2 from her bed to her wheelchair, wheeled R2 to the bathroom, transferred R2 to the toilet, removed R2's wet incontinence brief, put on a clean brief, put on pants, socks, bra and a top. With the same gloves, ULP-J wet a washcloth for R2 to wash her own face; ULP-J brushed R2's hair, removed a full trash can liner, replaced it with a clean liner and then removed her gloves. Without washing/sanitizing her hands, ULP-J put on a clean pair of gloves, made R2's bed, folded pajamas and assisted R2 to the dining hall. ULP-J removed her gloves, and without washing or sanitizing her hands, ULP-J poured and served juice to three residents in the dining hall. ULP-I On March 21, 2023, at 7:50 a.m. ULP-I was observed to set up medications at the medication cart. Using the same gloves at the time of medication set up, ULP-I went to a resident's room, administered eye drops and oral	0 510		

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0 510	Continued From page 4	0 510		

medications. ULP-I removed her gloves, completed documentation on the computer and donned a clean set of gloves (without washing or sanitizing her hands). With the new gloves, ULP-I set up another resident's medications. ULP-I locked the medication cart, poured water from a community water pitcher, entered the resident's room, and assisted with that resident's oral medication administration. ULP-I performed multiple steps, touching multiple surfaces with the same gloves and then failed to wash or sanitize her hands between glove use.

ULP-K
On March 21, 2023, at 8:30 a.m. ULP-K was observed to set up medications wearing gloves, lock the medication cart, unlock another door and entered a resident's room. ULP-K placed a lidocaine patch on the resident's back, removed one glove and handed oral medications to the resident to take. ULP-K assisted with a glass of water and then removed her other glove and used hand sanitizer. ULP-K touched multiple surfaces with the same set of gloves and administered medications without proper handwashing or hand sanitizing.

On March 22, 2023, at 2:00 p.m. RN-F stated the first topic covered in skills training was proper hand hygiene and staff should know the proper process. RN-F further stated, "Staff technically don't need to wear gloves when setting up medications, but only when handling certain routes of administration requiring glove use. Proper hand sanitizing between steps in set up, locking the medication cart, touching multiple surfaces and administration of medications is expected to be completed by all staff."

The licensee's Hand Hygiene policy dated August

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0 510	Continued From page 5 1, 2021, indicated the use of gloves does not replace handwashing. Hands should be washed or decontaminated: a. Before and after direct contact with a client, b. If moving from a contaminated body site to a clean body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and using a restroom No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	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 one of four residents (R3).	0 630		

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0 630	Continued From page 6 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 record lacked an individual abuse prevention plan to include an assessment of the resident's susceptibility to abuse by other individuals. R3 began receiving services on July 10, 2018, under the facility's comprehensive license and then on August 1, 2021, under the licensee's assisted living with dementia care license. R3's Service Plan dated January 24, 2023, indicated she received services to include medication administration, dressing/bathing/grooming assistance, compression stocking assistance, assist of one with transfers and escorts to meals. Additionally, R3's Service Plan indicated R3 did not pose a risk for abuse to others but lacked the indication of her susceptibility to abuse by another individual, including other vulnerable adults. On March 20, 2023, at 3:10 p.m. ULP-H was observed to provide R3 with a nebulizer treatment in R3's room. R3's AL (assisted living) Nursing Assessment dated March 9, 2023, page 12, section four included R3's risk of abusing other vulnerable adults; however, the assessment lacked an	0 630		

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0 630	Continued From page 7 indication of R3's susceptibility to abuse by another individual, including other vulnerable adults. On March 22, 2023, at 2:30 p.m. registered nurse (RN)-F confirmed R3's record lacked the above required content. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated he individual abuse prevention plan will be based upon an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults and risk of abusing other vulnerable adults. 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, 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	01060		

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01060	Continued From page 8 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 and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01060		

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01060	Continued From page 9	01060		

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:

R5 started receiving services on February 17, 2021.

R5's service plan last updated on December 8, 2022, indicated R5 received assistance with activities of daily living (ADL), medication administration, housekeeping, and laundry.

R5 was admitted to the hospital on November 3, 2022, and returned to the facility on December 8, 2022.

R5's record lacked a written notice including:
- 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.

In addition, R5's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not

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01060	Continued From page 10 returned to the facility within four days. On March 21, 2023, at 4:06 p.m. registered nurse (RN)-F confirmed R5's record did not have evidence the ombudsman was notified with an emergency relocation. RN-F stated they were familiar with this requirement, and it had been talked about at corporate director nursing phone calls, but they did not have it in place yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This	01440		

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01440	Continued From page 11 requirement also applies to staff who have not performed delegated tasks for one year or longer. 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) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two unlicensed personnel (ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 21, 2023, at 7:30 a.m. ULP-I was observed to administer medications to R2. ULP-I stated during her orientation period, she followed/shadowed another lead ULP as assigned, for a couple days and then performed direct care tasks with other ULP. ULP-I stated she had medication training with an RN and was "signed off" on that training before providing the service of medication administration. ULP-I could not recall when she was evaluated by a RN for competency for delegated tasks and other personal care duties. ULP-I was hired on November 7, 2022, to provide direct care services to residents under the	01440		

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01440	Continued From page 12	01440		

licensee's assisted living with dementia care license.
ULP-I's record indicated her first day of shadowing other ULP staff was on November 21, 2022.

ULP-I's record included an AL (assisted living) New Hire RA (resident assistant) Competency Skills Checklist-V5-Evaluator Review dated January 19, 2023, and signed by RN-F. The evaluation indicated ULP-I's competencies for medication administration, various delegated tasks, and personal care duties requiring an RN evaluation. The evaluation also included the statement which read, "This also serves as the 30-day supervisory visit by the RN."

On March 23, 2023, at 10:30 a.m. RN-F and assistant licensed assisted living director (ALALD)-C stated the licensee's training process for new ULP was for the newly hired ULP to attend various trainings provided by the licensee and the licensee's corporate office, and then follow an assigned ULP familiar with the routines of the residents. After a couple of shifts, the new hire ULP could perform some duties under the supervision of another ULP. The usual practice was for the RN to "sign off on competencies" after about day five of "on the floor training with a lead ULP." As written in New Hire Competency Skills Checklist, the licensee's practice is to count that evaluation also as the 30-day RN evaluation. RN-F stated she was unable to meet with ULP-I until January 19, 2023, to complete the RN competency evaluation and ULP-I had participated in personal cares and some delegated tasks to include blood sugar checks and compression stocking assistance to residents in the facility. RN-F stated there were no current newly hired staff who would be performing

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01440	Continued From page 13 delegated tasks without demonstrating competency to the RN. RN-F and ALALD-C stated they were not aware the RN 30-day supervisory evaluation could not be combined with initial RN competency evaluation and would further communicate this to the corporate office. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated a RN will supervise staff who perform delegated nursing, treatment or therapy services. Supervision of ULP by a RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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 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	01620		

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01620	Continued From page 14 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 reassessment not to exceed 90 days for one of four residents (R3) as required. Additionally, the licensee failed to accurately assess one of four residents (R3) for treatment services received. 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 unspecified illness, encephalopathy (disease that affects brain structure or function which causes altered mental state and confusion), cerebrovascular disease (a condition that affect blood flow to the brain) and cognitive communication deficit.	01620		

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01620	Continued From page 15 R3's Service Plan dated January 24, 2023, indicated she received services to include medication administration, dressing/bathing/grooming assistance, compression/TED (thrombo-embolic deterrent) stocking assistance, assist of one with transfers and escorts to meals On March 20, 2023, at 3:10 p.m. ULP-H was observed to provide R3 with a nebulizer treatment. R3's MAR dated March 1, 2023, through March 20, 2023, indicated R3 received one medication for dementia, three for depression/behavioral management, two for psoriasis, one protective skin ointment, one for blood thinning, one for high cholesterol, one diuretic (reduce fluid retention), one supplement, one nebulizer treatment for asthma, on for gastric reflux, two for bowel/constipation management, one vitamin supplement, one urinary tract supplement and one medication for mild pain. R3's task record dated March 1, 2023, through March 20, 2023, indicated staff provided assistance with TED stockings (on in the morning and off in the evening). R3's assessments for the previous six months were requested. 90-day assessments dated September 8, 2022, December 14, 2022 (97 days after the previous assessment), and March 9, 2023, were provided. The licensee failed to ensure the RN completed a reassessment not to exceed 90 days. R3's AL (assisted living) Nursing Assessment dated March 9, 2023, page 21. Treatment/Therapy Management Plan indicated	01620		

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01620	Continued From page 16 "N/A-Resident does not receive any treatments/therapy." Additionally, in section 7. Other medical needs, 2. indicate level of assistance for nebulizer treatments, option A. N/A was selected. The licensee failed to accurately identify the treatment of TED stockings in R3's assessments. On March 22, 2023, at 2:45 p.m. registered nurse (RN)-F confirmed the delayed date with R3's December 14, 2022, assessment and further stated "clearly there was an error with the assessment completed by the RN in reference to accurately assessing R3 for the treatments of TED stockings. By missing this in the assessment, we then failed to create a Treatment Plan as Medication and Treatment plans are driven by the RN assessment tool. The licensee's Initial and Ongoing Nursing Assessments of residents policy dated August 1, 2021, read, a Registered Nurse will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: Ongoing assessment: completed periodically but no less than every 90-days, and will include a list of treatments including the type, frequency, level of assistance needed and nursing needs, including potential to receive nursing-delegated services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days . .	01620		

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01750	Continued From page 17	01750		
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 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 delegated procedures were followed for one of four residents (R3) observed during 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 Service Plan dated January 24, 2023, indicated she received services to include medication administration.	01750		

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01750	Continued From page 18	01750		

R3's MAR dated March 1, 2023, through March 20, 2023, indicated R3 received one nebulizer treatment for asthma.

R3's AL (assisted living) Nursing Assessment dated March 9, 2023, in section 6. Medication Management, indicated Resident requires assistance with medication administration. Additionally, in section 4. Self Administration, 4. b 11. indicated resident cannot safely self administer medications without assistance.

On March 20, 2023, from 2:00 p.m. until approximately 3:00 p.m. R3 was observed playing bingo in the center area of the dementia care unit. R3 grew agitated at the end of the game, at 3:10 p.m. ULP-H was observed to escort R3 to her room, assisted with a transfer to R3's recliner and set up R3's scheduled nebulizer treatment. The medication was added to the nebulizer cup as attached to the nebulizer machine. The cup was attached on the other end to a blue spacer and mouthpiece which was then handed to R3 to place in her mouth to receive the medication. ULP-H turned on the nebulizer machine and told R3 to keep the nebulizer spacer in her mouth until it was finished and then left R3's room. ULP-H stated she just lets R3 handle the nebulizer on her own and will have the next set of staff check in on her in a while.

On March 22, 2023, at 2:45 p.m. registered nurse (RN)-F stated she expected staff to stay with R3 during her full nebulizer treatment as R3 should not be managing this on her own.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN

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01750	Continued From page 19 may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed if before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for three of three residents (R5, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01830		

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01830	Continued From page 20 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R5 R5 started receiving services on February 17, 2021, with a diagnosis of diabetes and dementia, and Parkinson's disease. R5's record included an annual prescriber's medication review completed on March 22, 2022. R5's undated, service plan indicated the resident received medication management services. R5's current medication administration record included atorvastatin (high cholesterol), aspirin, carbidopa/L-dopa, (antiparkinson agent), Eliquis (used for blood clots), and a multivitamin. R5's record lacked evidence of completing an annual renewal within the last twelve months of the last review date. R2 R2 began receiving services on June 10, 2020, under the facility's comprehensive license and then on August 1, 2021, under the licensee's assisted living with dementia care license. R2's Service Plan dated January 20, 2023, indicated she received services to include medication administration. R2's MAR dated March 1, 2023, through March 20, 2023, included two medications for depression/anxiety, one for mild pain, one for bowel/constipation, and one antacid.	01830		

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01830	Continued From page 21 A copy of R2's last signed medication orders was requested, but was not provided. R2's record lacked evidence of the licensee completed an annual renewal of her prescriptions. R3 R3 began receiving services on July 10, 2018, under the facility's comprehensive license and then on August 1, 2021, under the licensee's assisted living with dementia care license. R3's Service Plan dated January 24, 2023, indicated she received services to include medication administration. R3's MAR dated March 1, 2023, through March 20, 2023, indicated R3 received one medication for dementia, three for depression/behavioral management, two for psoriasis, one protective skin ointment, one for blood thinning, one for high cholesterol, one diuretic (reduce fluid retention), one supplement, one nebulizer treatment for asthma, on for gastric reflux, two for bowel/constipation management, one vitamin supplement, one urinary tract supplement and one medication for mild pain. A copy of R3's last signed medication orders was requested, but was not provided. R3's record lacked evidence of completing an annual renewal of her prescriptions. On March 23, 2023, at 8:35 a.m. registered nurse (RN)-F stated she could only find some signed medicatons orders from 2019 for both R2 and R3 (these were not provided to the surveyor); RN-F stated the licensee was "out of practice" with	01830		

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01830	Continued From page 22 getting annual medication prescription renewals for many of the residents throughout the facility. She stated, "we don't always get updated copies from the pharmacy, and even though we have an on site provider who frequently review medications, we have not ensured an annual renewal of medications had been completed and put in the resident's chart." The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy reviewed January 2020, indicated the nurse will assure that the prescriber renews a medication prescription or treatment or therapy order at least every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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 all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect the licensee's current residents,	01880		

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01880	Continued From page 23 staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 20, 2023, at approximately 9:30 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B indicated the licensee provided medication management to all 58 residents, and medications were securely stored in locked medication carts located in the medication rooms throughout the building. On March 21, 2023, at 8:30 a.m. unlicensed personal (ULP)-E and the surveyor entered the medication room and found the medication cart unlocked and unattended. On March 21, 2023, at 12:30 p.m. the surveyor entered medication room number three and found the medication cart unlocked and unattended. ULP-E was observed assisting residents in the dining room and leaving the medication cart unlocked. On March 22, 2023, at 12:30 p.m. registered nurse (RN)-F and RN-L confirmed the mediation carts should be locked at all times when they are not in the same room. The licensee's Storage of Medications policy	01880		

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01880	Continued From page 24 dated August 1, 2021, indicated when residents are living in a congregate setting the RN will develop a procedure to secure medication when they are delivered to the building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20316	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTENNIAL HOUSE APPLE VAL	14625 PENNOCK AVENUE APPLE VALLEY, MN 55124

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01940	Continued From page 25 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include the required content for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on March 20, 2023, at 10:30 a.m. registered nurse (RN)-B stated the licensee provided treatment management services to the licensee's residents. R3 R3's diagnoses included unspecified illness, encephalopathy (disease that affects brain structure or function which causes altered mental state and confusion), cerebrovascular disease (a condition that affect blood flow to the brain) and cognitive communication deficit. R3's Service Plan dated January 24, 2023, indicated she received services to include	01940		

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01940	Continued From page 26 compression/TED (thrombo-embolic deterrent) stocking assistance. R3's AL (assisted living) Nursing Assessment dated March 9, 2023, page 21. Treatment/Therapy Management Plan indicated "N/A-Resident does not receive any treatments/therapy." R3's task record dated March 1, 2023, through March 20, 2023, indicated staff provided assistance with compression stockings (on in the morning and off in the evening). R3's record lacked a Treatment Plan to include the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On March 22, 2023, at 2:45 p.m. RN-F stated R3's AL Nursing Assessment "was not completed	01940		

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01940	Continued From page 27 accurately to include TED stockings. When the assessment is completed correctly, it will "trigger" the Treatment Plan and the required content." The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, read b. When a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional must: i. Develop and maintain a current individualized treatment or therapy management record for each client that addresses the requirements of MN Statutes 144.4793, subd. 3. ii. Instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each client and determine that the unlicensed personnel have demonstrated the ability to competently follow the procedures: iii. Develop written specific instructions for each client and document those instructions in the client's record; iv. Communicate with the unlicensed personnel about the individual needs of the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	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.	02310		

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02310	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for three of three residents (R2, R3, R5) with bed rails. This resulted in an immediate correction order on March 21, 2023, at approximately 10:15 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R2 R2 began receiving services on June 10, 2020, under the facility's comprehensive license and then on August 1, 2021, under the licensee's assisted living with dementia care license. R2's diagnoses included Alzheimer's disease, history of right femur fracture (right hip fracture), and traumatic subarachnoid hemorrhage (brain bleed). R2's Service Plan dated January 20, 2023, indicated R2 received services to include medication administration, bathing/dressing/grooming assistance, assist of one for transfers and escorts for meals and activities. Additionally, the Service Plan indicated	02310		

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02310	Continued From page 29 VA (vulnerable adult) risk approved bed rail use and the resident/resident representative had been made aware of the risks verses benefits of bed rail use. R2's record included a bed rail consent signed on March 30, 2021. On March 21, 2023, at 7:30 a.m. unlicensed personnel (ULP)-I was observed to administer medications to R2 in her bed. R2's bed was a hospital bed with a right upper half bed rail in the upright position. R2's record included comprehensive assessments dated September 29, 2022, November 4, 2022, and January 25, 2023. The assessments included Functional Capabilities section 11. Indicate the supporting resources for resident to get in and out of bed. Option D. Hospital ½ bed rail on the right side of the resident's bed, ordered May 30, 2021, for repositioning and transfer assist; however, R2's record lacked the required measurements of the bed rail openings. R3 R3 began receiving services on July 10, 2018, under the facility's comprehensive license and on August 1, 2021, began receiving services under the licensee's assisted living with dementia care license. R3's diagnoses included unspecified illness, encephalopathy (disease that affects brain structure or function which causes altered mental state and confusion), cerebrovascular disease (a condition that affect blood flow to the brain) and cognitive communication deficit.	02310		

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02310	Continued From page 30 R3's Service Plan dated January 24, 2023, indicated she received services to include medication administration, dressing/bathing/grooming assistance, compression stocking assistance, assist of one with transfers and escorts to meals. On March 20, 2023, at 3:10 p.m. ULP-H was observed to provide R3 with a nebulizer treatment in R3's room. The surveyor observed an "M" shaped bed rail on the upper right side of R3's bed. The bed rail was secured with straps attached to both the base of the bed rail and to the bed frame. ULP-H stated R3 used the assistive device to stand when she got out of bed and grabbed the bar with turning in bed. R3's record included a Bed Rail Consent dated September 24, 2019, indicated Device: Bed mobility bars, Reason for use: repositioning and transfer assist. Circumstances for use: assist with bed mobility. The backside of the form included the risks verses benefits information and was signed by R3's resident representative on September 24, 2019. R3's record included a Fall Risk and Side Rail Assessment Tool dated September 8, 2022, section 12. Mobility/Safety Assessment" Side rails (bed rails) selection A. Side rails not indicated at this time was selected. R3's AL (assisted living) Nursing Assessments dated September 8, 2022, December 14, 2022, and March 9, 2023, indicated in Functional Capabilities section 11. Indicate the supporting resources for resident to get in and out of bed: A. N/A (not applicable) was selected.	02310		

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02310	Continued From page 31 R3's record lacked a bed rail assessment completed by a registered nurse (RN), manufacturer's instructions to ensure the rail was installed and being used appropriately, and evidence the consumer product safety commission (CPSC) was checked to ensure the bed rail was not recalled. R5 R5's started receiving services under the comprehensive home care licensee on February 17, 2021, and the assisted living with dementia care license on August 1, 2021, with diagnoses including Parkinson's disease, and dementia. R5's Service Plan dated January 31, 2023, included daily medication administration and activities of daily living (ADL). On March 20, 2023, at 12:10 p.m. the surveyor observed a hospital style bed with bilateral half rails in the up position near the head of R5's bed. The rails were attached to the bed frame. R5's record contained a bed rail consent form dated February 17, 2021, acknowledging the resident and resident representative were informed of the potential risks and benefits of bedrail use. R5's record included a fall risk and side rail assessment tool dated August 12, 2022, indicating they were needed and R5 had a hospital bed with half bedrails. The assessment did not include measurements. On March 21, 2023, at 11:00 a.m. RN-F indicated they were unaware measurements for bed rails was a requirement. RN-F further confirmed R3's record did not identify the resident had a bed rail. RN-F stated she was unsure if the bed rail was	02310		

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02310	Continued From page 32 just installed, or if the last two assessments were incorrect. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the 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 determine how best to keep the patient safe." The licensee's Bed Rails policy revised June 2022, indicated bed rails are only used when an assessment shows the benefit to the resident outweighs the risk of using a bedrail. The policy also indicates the person applying the bed rails to the bed must check to assure there are no gaps between the rail and the mattress or within the rails that is large enough to cause increased risk of injury. The policy did not address taking measurements of the bed rail. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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02310	Continued From page 33 On March 22, 2023, at 11:41 a.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *03/20/23*
Time: 08:28:33
Report: 1018231050

Food and Beverage Establishment Inspection Report

Location:
The Centennial House of Apple
14615 Pennock Avenue
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0010136
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Ecumen

Phone #: 9528912711
ID #: 54600

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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MAXIMUM TEMPERATURE REGISTERING THERMOMETER FOR THEIR DISHWASHERS. COMPLY WITH RULE.

Comply By: 03/31/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

ICE MACHINE IN KITCHEN TWO OBSERVED WITH SLIME BUILDUP ON THE BAFFLE INSIDE THE MACHINE. DISCUSSED WITH MANAGER TO HAVE THIS AREA CLEANED.

Comply By: 03/21/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER K1
Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit
Location: DISHWASHER K2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ MILK
Temperature: 40 Degrees Fahrenheit - Location: K2 COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: K2 COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 39 Degrees Fahrenheit - Location: K1 COOLER
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: K1 COOLER
Violation Issued: No

Process/Item: Cold Holding/ LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: K1 COOLER
Violation Issued: No

Process/Item: Hot Holding/ SOUP
Temperature: 181 Degrees Fahrenheit - Location: K1 WARMER
Violation Issued: No

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

INSPECTION COMPLETED WITH TRACEY FEARON (MDH) PRESENT

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS REPORTING.

DISCUSSED COOLING AND DATE MARKING PROCEDURES.

ESTABLISHMENT USES ONLY PASTEURIZED EGGS.

THERE ARE TWO KITCHEN IN THIS ESTABLISHMENT:
KITCHEN ONE LOCATED ON THE 14615 ADDRESS SIDE AND KITCHEN 2 LOCATED ON THE 14625 ADDRESS SIDE.

Food and Beverage Establishment Inspection Report

BOTH KITCHENS ARE UNDER THE SAME LICENSE AND WERE PART OF THE SAME SURVEY.

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 1018231050 of 03/20/23.

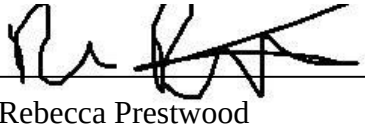
Certified Food Protection Manager: EDWARD A OVERTON

Certification Number: 111798 Expires: 05/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

MICHELLE BAUMAN
CULINARY DIRECTOR

Signed: 

Rebecca Prestwood
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