Electronically Delivered

June 22, 2023

Licensee
Cherrywood Of St. Cloud
1030 Voyageur Street
Saint Cloud, MN 56301

RE: Project Number(s) SL28983015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF ST CLOUD	1030 VOYAGEUR STREET SAINT CLOUD, MN 56301

(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: SL#28983015 On May 30, 2023, through June 1, 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 16 active residents; all of whom were receiving services under the Assisted Living/Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580		

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0 580	Continued From page 2 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living with dementia provider. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 May 30, 2023, at 9:30 a.m., the surveyor requested the licensee's quality management plan and meeting minutes. Clinical nurse supervisor (CNS)-B stated the facility had performed meetings monthly prior to COVID-19. CNS-B further stated the licensee did not currently have a quality management project and they have not been having quality management meetings.	0 580		

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0 580	Continued From page 3 The licensee's 2.31 Quality Management Program policy dated August 1, 2021, indicated licensee will always have at least one documented quality management project in place, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 4 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 01, 2023, at approximately 11:00 a.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and	0 810		

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0 810	Continued From page 5 every other month as required by statute. Provided documentation indicated that drills were completed on the following days and shifts: 5.17.23 pm shift, 5.15.23 am shift, 4.3.23 am shift, 2.20.23 pm shift, 1.24.23 am/pm shift, 9.9.22 am shift, and 9.9.23 pm shift. No fire drills were conducted on the overnight shift in the past year. During interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 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	01500		

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01500	Continued From page 6 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 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for one of two employees (clinical nurse supervisor (CNS)-B).	01500		

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01500	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-B was hired on March 17, 2017. On May 31, 2023, licensed assisted living director (LALD)-A provided CNS-B's undated Transcript training record and stated the document would contain all CNS-B's annual training. CNS-B's annual training record lacked the following required topics: - Reporting of maltreatment of vulnerable adults; - Review of the assisted living bill of rights; - Infections control techniques; - Review of policies and procedures; and - Principles of person-centered planning/service delivery. On May 31, 2023, at 1:26 p.m. CNS-B stated CNS-B must have not completed the assigned training within the licensee's online training program. CNS-B was unsure why CNS-B had not completed the required training. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021; indicated: All staff that perform direct care services will complete at least eight hours of annual training	01500		

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01500	Continued From page 8 for each 12 months of employment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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:	01530		

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01530	Continued From page 9 Based on interview and record review the licensee failed to provide evidence of annual dementia care training on required topics for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective January 1, 2023, through December 31, 2023. CNS-B CNS-B was hired on March 17, 2017, to provide supervision and oversite to unlicensed personnel and provide direct services residents. CNS-B's employee records lacked the annual dementia care training required. On May 31, 2023, at 1:26 p.m., CNS-B stated the assigned training within the licensee's online training program had not been completed. ULP-C ULP-C was hired on May 30, 2014, to provide direct care services under the licensee's assisted living with dementia care license.	01530		

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01530	Continued From page 10 ULP-C's employee record lacked two hours of annual dementia training as required. On May 31, 2023, at 1:27 p.m., CNS-B stated assigning dementia training was assigned to all staff and was unsure why ULP-C had not completed the required training. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated: All staff will complete two hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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 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	01620		

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01620	Continued From page 11	01620		

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) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for two of two residents (R1, R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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:

R1
R1 was admitted on January 11, 2021.

R1's assessment was completed on December 10, 2021, with the next assessment due within 90 days or by March 10, 2022. R1's record included a late 90-day assessment dated March 31, 2023, 476 days late.

R2
R2 was admitted on September 18, 2020.

R2's assessment was completed on September

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01620	Continued From page 12 30, 2021, with the next assessment due within 90 days or by December 29, 2021. R2's record included a late 90-day assessment dated May 4, 2023, 581 days late. On May 30, 2023, at 2:57 p.m., clinical nurse supervisor (CNS)-B stated CNS-B had oversight of resident's assessments and indicated the licensee was aware resident assessments were more than 90 days between assessments due to "trying to catch up from COVID-19 and the past RNs." The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated the nursing assessment by the registered nurse cannot exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF ST CLOUD	1030 VOYAGEUR STREET SAINT CLOUD, MN 56301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 13 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan (ITMP) to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on September	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	06/02/2023

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01940	Continued From page 14 18, 2020, under the former comprehensive home care license and converted to assisted living with dementia care license on August 1, 2021. R2's diagnoses included post polio syndrome, generalized anxiety disorder, obstructive sleep apnea (breathing stops involuntary for brief periods of time during sleep). R2's Service Plan dated May 31, 2023, indicated R2 received following services dressings, self-feeding, oral hygiene, hair care, grooming, bathing, medication administration, transfers, treatments CPAP, TED (anti-embolism) stockings, laundry, and housekeeping. . R2's medication administration record for May 2023, indicated services for CPAP care twice a day, TED stockings twice a day and nebulizer as needed. On May 31, 2023, at 8:28 a.m., the surveyor observed ULP-C administer R2's morning medication, CPAP care, and apply TED stockings. R2's ITMP lacked the following 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.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 15 On May 31, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated CNS-B had oversight of the ITMP indicating CNS-B was aware of the lack of the required content for R2's ITMP. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 1, 2021, indicated: Licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at the following: a. a statement of the type of services that will be provided; b. documentation of specific resident instructions relating to the treatments or therapy administration; c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and e. any resident-specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	06/02/2023

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02170	Continued From page 16 (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized activity plan based on the activity evaluation for two of two residents (R1, R2) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28983	A. BUILDING: _____ B. WING _____	06/02/2023

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02170	Continued From page 17 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: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective January 1, 2023, through December 31, 2023. On May 30, 2023, at 10:50 a.m., the surveyors conducted a facility tour of the ALFDC building and noted activity calendars posted. R1 R1's diagnoses included dementia, major depressive disorder, and anxiety. R1's Service Plan dated May 30, 2023, indicated R1 received services including assistance with dressing, hygiene, assistance with self- feeding, hair care, grooming, toileting, bathing, modified diets, medication administration, transfers, laundry, and housekeeping. R1's record lacked an evaluation for activities which included the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02170	Continued From page 18 R2 R2's diagnoses included post polio syndrome, generalized anxiety disorder, obstructive sleep apnea (breathing stops involuntary for brief periods of time during sleep). R2's Service Plan dated May 31, 2023, stated R2 received following services dressings, self-feeding, oral hygiene, hair care, grooming, bathing, medication administration, transfers, treatments CPAP, TED (anti-embolism) stockings, laundry, and housekeeping. R2's record lacked an evaluation for activities which included the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. On May 30, 2023, at 2:57 p.m., clinical nurse supervisor (CNS)-B stated CNS-B had oversight and was not aware of the lack of the required content for resident's individualized activity plan. CNS-B stated CNS-B had prepared a new template that had not been utilized with the required content. The licensee's 1.34 Activity Programming dated August 1, 2021, indicated the licensee will provide a wide range of activities and social recreation for residents. No further information was provided.	02170		

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	28983	A. BUILDING: _____ B. WING _____	06/02/2023

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02170	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/30/23*
Time: 11:28:58
Report: 1037231130

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Of St Cloud
1030 Voyageur Street
St Cloud, MN56301
Stearns County, 73

Establishment Info:
ID #: 0038720
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202577445
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.

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

AT TIME OF INSPECTION, THERE WERE NO HANDWASHING SIGNS POSTED AT THE HANDWASHING SINKS IN BOTH KITCHENS. PROVIDE A SIGN AT ALL HANDWASHING SINKS USED BY FOOD EMPLOYEES.

Comply By: 05/31/23

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: SHRIMP PASTA SALAD - 1036 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK JUG - 1036 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SHRIMP PASTA SALAD - 1030 KITCHEN
Violation Issued: No

Type: Full
Date: *05/30/23*
Time: 11:28:58
Report: 1037231130
Cherrywood Of St Cloud

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK JUG - 1030 KITCHEN
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1037231130 of 05/30/23.

Certified Food Protection Manager CASEY HAMANN

Certification Number: 79395 Expires: 11/02/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231130

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1	Date	05/30/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:28:58
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Cherrywood Of St Cloud	1030 Voyageur Street	St Cloud, MN	56301	3202577445

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038720		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status					COS	R
Supervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A (N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A (N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A (N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A (N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	(IN)	OUT	N/A N/O	Proper date marking & disposition		
24	IN	OUT	(N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	IN	OUT	(N/A)	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	(N/A)	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 05/30/23

Inspector (Signature) Michelle L Thomas