Electronically Delivered

March 5, 2025

Licensee
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21389016

Dear Licensee:

On January 27, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 20, 2024, 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Electronically Delivered

January 3, 2025

Licensee
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21389016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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 Department of Health 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.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21389016-0 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on November 19, 2024, at a level 3/Widespread (I). The licensee took action on November 19, 2024; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 4 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 facility tour on November 19, 2024, from 11:25 a.m. through 12:35 p.m. with maintenance supervisor (MS)-I and licensed assisted living director (LALD)-B the surveyor observed the following: The exterior exit doors were locked, and a keypad code was required to unlock the doors. There was a blue pull station device next to the keypad that read "Pull For Door Release". Building 1895 had a zip tie locking the pull station device, rendering it inoperable. The pull station device must be accessible and operable at all times so the door can be unlocked without the use of the keypad during fire or similar emergency. MS-I removed the zip tie during the tour and stated they understood the requirement. The fire-resistant rated doors leading into the laundry room in building 1875 and 1855 were equipped with automatic door closers but the doors did not fully close and latch on their own. Fire-resistant rated doors are required to automatically close and latch to prevent the spread of fire and smoke to adjoining building areas. MS-I stated they understood the requirement and would adjust the door closers. Emergency lights in building 1855 by resident	0 780		

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0 780	Continued From page 5 room 10 and building 1875 by resident 3 did not work when tested by MS-I. Emergency lights are required to automatically come on during power failure to provide light to emergency exit routes. MS-I verified the finding and stated they would replace the lights. The facility was equipped with an automatic fire sprinkler system that was monitored by a fire alarm system. The main fire alarm panel had an inspection tag from a third-party agency with a date of June 28, 2023, which was more than one year prior to this survey. The surveyor asked for the most recent fire alarm report and LALD-B stated they would email the report. LALD-B emailed "Fire Alarm and Emergency Communications Systems Inspection Report" dated June 28, 2024, to the surveyor on November 22, 2024. The report listed system deficiencies and required corrections. On November 26, 2024, the surveyor emailed LALD-B and asked LALD-B to verify if the deficiencies noted in the report had been corrected. LALD-B emailed the surveyor on December 9, 2024, and stated that the corrections noted in the fire alarm report were scheduled to be fixed. LALD-B stated she was under the impression that this had already been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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01290	Continued From page 6 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for three of 49 employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-G and ULP-H). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on November 19, 2024. 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).	01290		

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01290	Continued From page 7 The findings include: On November 18, 2024, at 4:15 p.m., the licensee provided the surveyor with the licensee's NETStudy roster as printed by their human resources manager. CNS-A CNS-A was hired on November 4, 2001, to provide nursing and direct care services for the licensee's residents. CNS-A's record included a registered nurse (RN) license issued by the Minnesota Board of Nursing effective August 21, 1997, with an expiration date of September 30, 2026. On November 18, 2024, at 1:00 p.m., CNS-A was observed interacting with various residents in the facility. On November 19, 2024, at 8:45 a.m., the surveyor and licensed assisted living director (LALD)-B reviewed the NETStudy 2.0 roster as printed on November 18, 2024. The roster included the employees affiliated with the licensee's health facility identification number (HFID) 21389. CNS-A's background study was affiliated to HFID 21389, but indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022. LALD-B stated she understood if the licensee's nurse reported to and relicensed with the Minnesota Board of Nursing, she was tracked by the nursing board and the fingerprinting was not required. The licensee failed to ensure CNS-A had a current and eligible background study.	01290		

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01290	Continued From page 8 ULP-G ULP-G had a hire date of April 3, 2024, to provide direct care services for the licensee's residents. On November 19, 2024, at 10:07 a.m., the surveyor and LALD-B reviewed the NETStudy roster as printed on November 18, 2024. ULP-G was not listed on the licensee's NETStudy roster. LALD-B then accessed the NETStudy 2.0 roster online and noted ULP-G's background study to be listed on the roster with an affiliation date of November 19, 2024. Further review of ULP-G's NETStudy affiliations dated November 19, 2024, indicated ULP-G had a cleared background study associated with HFID 21389 on March 24, 2023, and then separated from the licensee on March 29, 2023. The licensee failed to ensure ULP-G's background study clearance was current and affiliated until November 19, 2024. ULP-H ULP-H had a hire date of March 19, 2024, to provide direct care services for the licensee's residents. On November 19, 2024, at 10:10 a.m,. the surveyor and LALD-B reviewed the NETStudy roster as printed on November 18, 2024. ULP-H was not listed on the licensee's NETStudy roster. LALD-B then accessed the NETStudy 2.0 roster online and noted ULP-H's background study clearance to be listed on the roster with an affiliation date of November 18, 2024. Further review of ULP-H's NETStudy roster dated November 19, 2024, indicated ULP-H had an affiliation with HFID 20705 (a sister facility) on	01290		

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01290	Continued From page 9 March 5, 2024; with a noted separation date of November 18, 2024. ULP-H's affiliation with the licensee's HFID 21389 was dated November 18, 2024. The licensee failed to ensure ULP-H's background clearance was affiliated with the facility's HFID number. On November 19, 2024, at 10:25 a.m., LALD-B stated the licensee's human resources manager affiliated ULP-G's background clearance on November 19, 2024, and ULP-H's background clearance after the surveyor received the original NETStudy roster on November 18, 2024. LALD-B stated she was not aware of ULP-G's employment break/affiliation need. On November 19, 2024, at 12:54 p.m. LALD-B stated CNS-A, ULP-G and ULP-H had been working independently, without direct supervision. The licensee's policy titled Criminal Background Checks dated June 1, 2022, noted: -A criminal background check with the State required agency must be completed for all employees, volunteers, board members, and contracted individuals who provide direct care or contact with residents under the following conditions: a. Upon offer of employment; b. When returning from a leave of absence of 120 consecutive days or more; c. When and as otherwise required by law; d. Prior to defined types of volunteer service; e. Prior to board appointment. * Except in MN not needed for individuals who have a license issued by a health licensing board and have completed a criminal background as required by that board. Board of Nursing, Board	01290		

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01290	Continued From page 10 of Executives for Long Term Services and Supports (Administrators), Board of Social Work, Board of Physical Therapy, Board of Occupational Therapy Practice, Board of Pharmacy, Board of Dietetics and Nutrition Practice. Licensed Assisted Living Directors should still be run through Net Study. The Minnesota Department of Human Services website updated July 31, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid and modifications ended January 1, 2023. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action on November	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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
01290	Continued From page 11 19, 2024. Deficiency remains at a scope/level of I.	01290		
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 permitting only authorized personnel access. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on November 18, 2024, at 11:15 a.m., clinical nurse supervisor (CNS)-A indicated the licensee provided medication management to all 28 residents, and medications were securely stored in a locked medication cart and locked medication room in each of the three dementia care units.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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
01880	Continued From page 12 On November 19, 2024, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-F during medication set up in the medication room. ULP-F set up nine oral medications and one bottle of eye drops for R4. ULP-F mixed R4's MiraLAX (used for constipation) with eight ounces of water, crushed the remaining pills as ordered, and mixed them with applesauce. ULP-F took the medications to the dining room table where R4 was seated at a table across from another resident as they waited for breakfast to be served. The surveyor observed three additional residents seated in the dining room at two other tables; furthermore, another resident (R5) was observed wandering around the unit, in and out of the dining room area. ULP-F administered the medications mixed in applesauce and gave R4 a sip of her MiraLAX. ULP-F then asked R4 if she could assist her to her room to administer her eye drops in private; to which R4 agreed. ULP-F set R4's MiraLAX on top of a cabinet behind R4. The MiraLAX was at waist level and still within reach of any resident, visitor, and staff. At 8:30 a.m., ULP-F pushed R4 to her room (out of the sight of the dining room). Another staff was preparing breakfast trays in the kitchen beyond the dining room and not in direct sight of the residents nor the MiraLAX. ULP-F did not ask for another staff to monitor the glass of MiraLAX in her absence. Upon entrance to R4's room, the surveyor and ULP-F observed R5 wandering around in the room. ULP-F escorted R5 out and closed the bedroom door. ULP-F then administered R4's eye drops. At 8:35 a.m., ULP-F then returned R4 to the dining room area. R5 was observed still wandering throughout the unit. R4's glass of MiraLAX remained in the same location and appeared undisturbed; however, ULP-F left the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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
01880	Continued From page 13 glass of MiraLAX unattended for five minutes. ULP-F failed to provide proper medication storage and security for R4's MiraLAX. On November 19, 2024, at 8:40 a.m., ULP-F stated the staff are directed not to have food/drink items in the medication room, and medications were not allowed in the kitchen preparation area. ULP-F stated she would need to discuss alternative options to ensure medication security in the event she needed to attend to other tasks or other residents. ULP-F stated she recognized R5 was wandering and had access to the unattended MiraLAX. On November 19, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated she and ULP-F had discussed the need to always ensure medication security and not leave medications unattended and accessible for any other resident. The licensee's Medication Storage-AL dated November 4, 2024, indicated compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *11/19/24*
Time: 11:00:00
Report: 1047241325

Food and Beverage Establishment Inspection Report

Location:
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0039272
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522338811
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TEMPERATURE IN ARCTIC AIR COOLER IN HOUSE 2 WAS WARMER THAN 41F. CORRECTED ON SITE- FACILITY ADJUSTED TEMPERATURE. NEW TEMPS OF TCS FOOD WERE ALL COLDER THAN 41F

Comply By: 11/19/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

REPEAT VIOLATION- FIRST ISSUED 11/2/21.

COUNTERS AND CABINETS IN HOUSE 1 AND 3 ARE LAMINATE OVER COMPOSITE WOOD. COUNTERS SHOW SIGNS OF DAMAGE. THESE SHOULD BE REPLACED WITH A NON-ABSORBENT, SMOOTH SURFACE IN THE EVENT OF REMODEL OR FURTHER DAMAGE

Comply By: 11/19/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer dispenser
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 47 Degrees Fahrenheit - Location: #2 arctic air- gravy
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: #1 arctic air- milk
Violation Issued: No

Process/Item: Hot Holding
Temperature: 148 Degrees Fahrenheit - Location: #1 cayenne warmer- gravy
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: #3 arctic air- ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: #2 arctic air- turkey (corrected)
Violation Issued: No

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

Inspection conducted with operator and reviewed with MDH Nurse Evaluator D. Jacobson.

The facility has three kitchenettes- one for each house. Each kitchenette has at minimum a handwashing sink, refrigerator, additional sink, and a dishwasher.

The dishmachines in houses 1 & 3 are not currently operational- all dishes must be sanitized in kitchen 2 until the other machines are working properly.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Type: Full
Date: *11/19/24*
Time: 11:00:00
Report: 1047241325
Emerald Crest Of Shakopee

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047241325 of 11/19/24.

Certified Food Protection Manager: Victoria S. Taylor

Certification Number: FM99998 Expires: 07/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ericka Merino Ortiz
Culinary Director

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us