Electronically Delivered

January 13, 2022

Administrator
Arbor Glen Senior Living
11020 39th Street North
Lake Elmo, MN 55042

RE: Project Number(s) SL33357015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 2, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health 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 Department of Health 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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33357	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN SENIOR LIVING	11020 39TH STREET NORTH LAKE ELMO, MN 55042

(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 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: #SL33357015 On November 30, 2021, through December 2, 2021, 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 74 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 1 (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 maintain the smoke alarms in rooms #213, #240, #254, and #274 as required by Minnesota Statutes, 144G.45, Subd. 2. 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 780		

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0 780	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2021, between 10:30 a.m. and 1:00 p.m., the surveyor toured the facility with the director of maintenance (DM)-F and observed the following: 1. The smoke alarms located inside the sleeping room #213 and smoke alarms located outside the vicinity of the bedrooms #254 and #274 were not in proper working order. All three smoke alarms had no blinking (flashing) red or green lights to indicate proper functioning. DM-F verified the alarms were not in proper working order and stated it was safer to replace the smoke alarms than to repair them. The surveyor explained that the wire may be loose and needed to be looked at closer. 2. The smoke alarm in room #240 was removed and missing from the bracket housing on the ceiling. DM-F located the alarm on the counter. During an interview on December 1, 2021, at approximately 4:10 p.m., licensed assisted living director (LALD)-C acknowledged the surveyor's findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 810		

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0 810	Continued From page 3 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 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 interview and record review, the licensee failed to provide the required training to staff and residents on fire safety and emergency evacuation. In addition, the fire protection procedures for the residents required further review to accurately address the proper actions to be taken by residents for fire safety. This had the	0 810		

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0 810	Continued From page 4 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) 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: On December 1, 2021, at approximately 1:05 p.m., the surveyor received the fire safety and evacuation plan documentation, including records of evacuation drills and records of required training from licensed assisted living director (LALD)-C for review. The surveyor noted: 1. The documented policy on training of employees on fire safety and evacuation did not meet the minimum required frequency of twice per year. The facility's Fire Safety Plan Policy dated August 1, 2021, stated new employees will receive the fire safety and evacuation training upon hire at orientation and annually. 2. No documented records of required twice per year employee training on fire safety and emergency evacuation. 3. No documented policy on required training schedule of residents who could assist in their own evacuation or proper actions to be taken in the event of a fire or emergency for their safety, including movement, evacuation, or relocation. 4. Fire protection procedures for residents included instructions for residents to "use fire extinguishers," "aim at the base of the fire," and "exit the building." Resident fire procedures must be reviewed for the well-being and safety of dementia care residents during a fire and similar	0 810		

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0 810	Continued From page 5 emergency. During an interview on December 1, 2021, at approximately 4:10 p.m., the LALD-C acknowledged the surveyor's findings. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01620 SS=E	144G.70 Subd. 2 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 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:	01620		

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01620	Continued From page 6 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 90-day comprehensive nursing assessment with all required content for two of five residents (R3 and R5) with records reviewed. 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: R3 admitted to licensee on December 19, 2017. R3's service plan dated August 10, 2021, indicated R3 received services, including medication set-up, medication administration, INR Checks (test to measure the time for blood to clot), laundry, and activities of daily living. R3's Master Assessment 2.0 was dated and signed by a RN on August 9, 2021. R3's record lacked further comprehensive assessments to be completed every 90-days. During an interview on December 2, 2021, at approximately 11:30 a.m., RN-E stated the Master Assessment 2.0 had not been completed by the nurse within 90-days for R3, and the licensee was behind on this assessment. R5 admitted to the licensee on September 24, 2018.	01620		

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01620	Continued From page 7 R5's service plan signed and dated July 2, 2021, indicated R5 received services, including blood sugar checks, bed making, laundry, medication administration, wound care, escort service, safety checks, and toileting. R5's Master Assessment 2.0 was dated and signed by a RN on August 4, 2021. R5's second Master Assessment 2.0 was dated and signed by a RN on December 1, 2021. During an interview on December 2, 2021, at approximately 10:15 a.m., RN-E stated the ongoing resident monitoring at least every 90 days was past due, and the licensee was behind in R3 and R5's assessments. The licensee's Assessment of Clients - Initial and Ongoing policy, dated August 1, 2021, indicated assessments "not to exceed 90 calendar days from the client's last date of the uniform assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written	01790		

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01790	Continued From page 8	01790		

information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before

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01790	Continued From page 9	01790		

the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for the unlicensed personnel (ULP) providing medications for residents with unplanned time away from home when the licensed nurse was not available.

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:

ULP-B's Supervision of Home Care Personnel form dated May 5, 2020, indicated ULP-B received annual supervision for medication administration, but lacked training or supervision for unplanned time away policy and procedure.

During an interview on December 2, 2021, at

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01790	Continued From page 10 approximately 11:30 a.m., RN-E stated ULPs are provided information about unplanned times away from home during their initial training, but no competencies are completed and maintained in the employee records. RN-E stated the policy indicated ULPs are to call the nurse and receive instructions on setting up the medications for the resident. The licensee's undated Medication Administration Guidelines training for unplanned times away read, "Under the direction of a nurse, unlicensed staff are able to set up medication with the required packaging, labeling and instructions for a client who will be away from home unexpectedly for up to 120 hours (5 days)." The licensee's Medication Management - Client Away from Home policy, dated August 1, 2021, lacked identification of training and competencies of ULPs delegated the task of providing medications to residents for unplanned time away from home. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040		

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02040	Continued From page 11 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a complete hazard vulnerability or safety risk assessment performed on and around the property. including mitigations to protect dementia care residents from harm. This has 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) 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: On December 1, 2021, at approximately 1:05 p.m., the surveyor received the hazard vulnerability plan documentation for review. The documentation lacked specific hazards on and around the property including de-activation of powered doors during a fire emergency or highway emergencies adjacent to the facility. In addition, no mitigations were documented to protect against potential hazards. During an interview on December 1, 2021, at approximately 4:10 p.m., licensed assisted living director (LALD)-C acknowledged the surveyor's	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33357	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN SENIOR LIVING	11020 39TH STREET NORTH LAKE ELMO, MN 55042

(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
02040	Continued From page 12 findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33357	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN SENIOR LIVING	11020 39TH STREET NORTH LAKE ELMO, MN 55042

(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
02110	Continued From page 13	02110		

and from outside medical appointments; and
(10) safekeeping of residents' possessions.
(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R1, R2, R3, R4, and R5) with records reviewed.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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 included:

Review of R1, R2, R3, R4, and R5's records included no documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility.

On December 2, 2021, at approximately 11:30 a.m., licensed assisted living director (LALD)-C and regional registered nurse (RN)-E provided a document titled, Assisted Living with Dementia Care Policies and Procedures Disclosure (144G.82). The document included all policies and procedures required to be disclosed to residents prior to move-in. RN-E stated the packet was created but was not provided to any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33357	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 14 residents receiving services by the licensee. The licensee's Dementia Memory Care Facility Program Disclosure Requirements policy dated December 2, 2020, lacked identification of required policies and procedures to be provided to residents at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *11/30/21*
Time: 10:24:55
Report: 1018211163

Food and Beverage Establishment Inspection Report

Location:
Arbor Glen Senior Living
11020 39th Street North
Lake Elmo, MN55042
Washington County, 82

Establishment Info:
ID #: 0039120
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517041444
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

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

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

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

Food and Equipment Temperatures

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

Process/Item: Cold Holding/ SAUSAGE
Temperature: 38 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

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

Process/Item: Cold Holding/ DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ LETTUCE
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Holding/ SOUP
Temperature: 168 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

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

VIEWED ILLNESS LOG AND DISCUSSED EMPLOYEE ILLNESS POLICY.

NO ORDERS ISSUED DURING THIS INSPECTION.

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

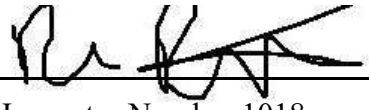
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018211163 of 11/30/21.

Certified Food Protection Manager: MARK W TUFENK

Certification Number: FM14504 Expires: 09/21/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JACLYN KISSINGER
KITCHEN MANAGER

Signed: 
Inspector Number 1018

6512014500