DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

February 2, 2022

Administrator
Brookdale Edina
3330 Edinborough Way
Edina, MN 55435

RE: Project Number(s) SL20381015

Dear Administrator:

On January 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 9, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

pmb

Electronically Delivered

December 2, 2021

Administrator
Brookdale Edina
3330 Edinborough Way
Edina, MN 55435

RE: Project Number(s) SL20381015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 9, 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 Home Care 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 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

**The total amount you are assessed is $500.00.** You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**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. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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
St. Paul, MN 55164-0970

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

**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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20381 | A. BUILDING: _____ B. WING _____ | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE EDINA | 3330 EDINBOROUGH WAY EDINA, MN 55435 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#20381015<br><br>On November 8th and 9th, 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 149 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.A<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted in a central location, potentially affecting the licensee's current residents, staff and any visitors of the licensee.<br><br>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 | 0 470 | | |

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| 0 470 | Continued From page 2<br>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).<br><br>The findings include:<br><br>The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to:<br>- include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked<br>- identify the direct-care staff members resident assignments or work location<br>- be posted after redacting direct-care staff members resident assignments, at the beginning of each work shift in a central location in each building<br><br>On November 8, 2021, at 9:20 a.m., during the tour of the licensee's facility, a staffing schedule was not posted.<br><br>On November 8, 2021, at 9:30 a.m., licensed assisted living director (LALD)-A confirmed the staffing schedule for the day had not yet been posted.<br><br>The licensee's Staffing Requirements policy dated August, 2021, indicated the daily work schedule must be posted at the beginning of each work shift in a central location of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |

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| 0 480 | Continued From page 3 | 0 480 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all one hundred forty-nine residents receiving assisted living services.<br><br>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). | 0 480 | | |

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| 0 480 | Continued From page 4<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated, November 08, 2021, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the license failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. This had the potential to affect all one hundred forty-nine residents receiving assisted living services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 510 | | |

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| 0 510 | Continued From page 5<br>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).<br><br>The findings include:<br><br>Lack of eye protection<br><br>On November 9, 2021, at 7:00 a.m., unlicensed personnel (ULP)-D was observed to provide direct care to resident (R1), including blood glucose monitoring, oral and subcutaneous medication administration without eye protection.<br><br>On November 9, 2021, at 2:30 p.m., registered nurse (RN)-B verified staff are supposed to wear eye protection during direct care.<br><br>The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated on page 1 of 3, heath care worker (HCW) with face-to-face contact with COVID-19 negative clients are to wear eye protection.<br><br>The licensee's Infection Prevention and Control Plan dated, August 2021, indicated skilled nursing associates should wear a face mask and face shields for the first 14 days when entering new admissions rooms for prevention of COVID-19 infections in the communities. The licensee's Standard Precautions policy dated August 2021, indicated associates should wear eye protection as indicated by the potential for contact with blood or body fluids. | 0 510 | | |

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| 0 510 | Continued From page 6<br>Hand Hygiene (HH)<br><br>The licensee failed to ensure staff performed hand hygiene according to the Centers for Disease Control and Prevention (CDC) and MDH guidelines.<br><br>The CDC document titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated December 14, 2020, indicated healthcare personnel (HCP) should perform hand hygiene (HH) before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHR) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds.<br><br>On November 9, 2021, at 7:30 a.m., ULP-F performed a blood glucose fingerstick on a resident and administered medications. ULP-F did not perform HH before or after the resident's finger stick and administering the resident's medications.<br><br>On November 9, 2021, at 7:53 a.m., ULP-F did not perform HH before or after administering medications to a resident.<br><br>On November 9, 2021, at 7:59 a.m., ULP-F did not perform HH before or after administering medications to a resident.<br><br>On November 9, 2021, at 8:00 a.m., ULP-F did not perform HH before or after administering medications to R5. | 0 510 | | |

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| 0 510 | Continued From page 7<br><br>On November 9, 2021, at 8:05 am., ULP-F did not perform HH before or after administering medications to R4.<br><br>On November 9, 2021, at 8:30 a.m., ULP-F stated the facility provided infection control and HH training. ULP-F verified she was supposed to perform HH between residents. ULP-F stated she got busy and forgot to perform HH between residents.<br><br>The licensee's Infection Prevention and Control Plan dated, August 2021, indicated skilled nursing associates should perform HH before and after assisting residents for prevention of COVID-19 infections in the communities.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced | 0 550 | | |

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| 0 550 | Continued From page 8<br>by:<br>Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all one hundred forty nine residents receiving assisted living services.<br><br>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).<br><br>The findings include:<br><br>The licensee lacked a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of posting in the common area of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to the MAARC.<br><br>On November 8, 2021, during a facility tour at approximately 9:25 a.m., the facility's common areas lacked the required posting of the | 0 550 | | |

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| 0 550 | Continued From page 9<br>grievance procedure and Ombudsman contact information and information on how to report suspected maltreatment.<br><br>On November 9, 2021, at 2:20 p.m., licensed assisted living director (LALD)-A confirmed the above listed information was not posted.<br><br>The licensee's Grievance Procedure policy dated August 2021, indicated that at any point in the grievance process, if requested, a community representative should assist the resident or resident responsible party in forwarding a written grievance to the appropriate address and contact person. The policy lacked information on posting in a conspicuous place, the licensee's grievance procedure and contact information for Ombudsman and the Minnesota Adult Abuse Reporting Center.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 630 SS=D | 144G.42 Subd. 6 Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes | 0 630 | | |

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| 0 630 | Continued From page 10<br>self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan included an identification of a person's risk of abusing others for one of six residents (R1) reviewed, and failed to develop an individual abuse prevention plan for one of six residents (R4) reviewed.<br><br>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).<br>The findings include:<br>R1's diagnoses included anxiety and major depressive disorder.<br>R1's Individual Abuse Prevention Plan dated, October 22, 2021, indicated R1 did not have a history of physical aggression or other potentially harmful behaviors toward others. R1's medical record included a Psychiatry History and Physical dated October 13, 2021, which indicated R1 had a restraining order served by his wife for placing his hand around his wife's neck.<br>On November 9, 2021, registered nurse (RN)-B confirmed R1's individual abuse prevention plan lacked an identification of the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse.<br>R4's diagnoses included dementia. | 0 630 | | |

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| 0 630 | Continued From page 11<br><br>On November 9, 2021, at 8:15 a.m., unlicensed personnel (ULP)-G administered oral medications to R4. ULP-G stated R4 was a fall risk and required staff assistance with ambulation.<br><br>R4's record lacked development of an abuse prevention plan to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>On November 9, 2021, at approximately 1:45 p.m., licensed assisted living director (LALD)-A stated R4 was recently admitted and confirmed an individual abuse prevention plan had not been completed.<br><br>The licensee's Individual Abuse Prevention Plan policy dated August 2021, indicated, upon move in, each resident should have an individual abuse prevention plan completed and the vulnerability of each resident would be addressed on the service plan for associates to have awareness of a resident's vulnerable areas with ways to individually manage these concerns to minimize the risk of abuse or neglect for the resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 630 | | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of | 0 650 | | |

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| 0 650 | Continued From page 12<br>each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br>(b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees/unlicensed personnel (ULP-G) reviewed.<br><br>This practice resulted in a level two violation (a | 0 650 | | |

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| 0 650 | Continued From page 13<br>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).<br><br>The findings include:<br><br>ULP-G had a hire date of September 14, 2016.<br><br>ULP-G's employee record lacked evidence of a performance review since date of hire.<br><br>On November 9, 2021, at approximately 11:00 a.m., business office manager (BOM)-H indicated ULP-G should have had annual performance evaluations, but if the documentation is not located in the employee file, the performance evaluations probably had not been completed.<br><br>The Brookdale Senior Living Associate Handbook, dated 2019, stated all associates will have their performance formally appraised at least once per year.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 650 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements: | 0 680 | | |

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| 0 680 | Continued From page 14<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan prominently posted. This had the potential to affect all one hundred forty-nine residents receiving assisted living services.<br>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). | 0 680 | | |

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| 0 680 | Continued From page 15<br><br>The findings include:<br><br>On November 8, 2021, at 10:00 a.m., during the tour of the licensee's facility, an emergency preparedness plan was not posted in a central location.<br><br>On November 9, 2021, at 1:46 p.m., licensed assisted living director (LALD)-A verified the emergency preparedness plan was not posted prominently.<br><br>The licensee's policy related to posting the written emergency preparedness plan was requested but not provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 730 SS=A | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health | 0 730 | | |

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| 0 730 | Continued From page 16<br>records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R6) reviewed.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than | 0 730 | | |

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| 0 730 | Continued From page 17<br>a minimal impact on the resident and does not affect health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br>The findings include:<br>R6 was discharged on September 28, 2021. R6's record lacked a discharge summary.<br><br>On November 8, 2021, at approximately 11:40 a.m., licensed assisted living director (LALD)-A indicated R6 had no discharge summary in the record.<br><br>The licensee's policy titled MN Discharge policy, dated August 2021, indicated a discharge summary should be prepared and provided to the resident and the resident's representative at time of discharge.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 730 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, | 0 810 | | |

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| 0 810 | Continued From page 18<br>evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide fire safety and evacuation training at least twice per year after hire to employees and failed to perform evacuation drills twice per year per shift with at least one evacuation drill every other month.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 19<br>a large portion or all of the residents).<br><br>The findings include:<br><br>Fire Safety Training<br>On November 9, 2021 between approximately 10:00 a.m. and 10:35 a.m., dining services director (DSD)-I and maintenance director (DM)-J stated that the facility used an automated training system called "Tels", which prescribed monthly training exercises for all staff.<br><br>Review of the assigned trainings by the Tels system indicated the general fire-based trainings lacked exclusive fire safety trainings and evacuation plans for the specific facility. Additionally, the "Tels" system lacked the frequency of training to require employees be trained twice per year after initial hire, as required by statute.<br><br>Evacuation Drills<br>On November 9, 2021 between approximately 10:00 a.m. and 10:35 a.m., DSD-I and DM-J stated that the facility did not have records for evacuation drills. The licensee lacked record of documentation to indicate they had conducted any evacuation drills for employees.<br><br>A policy was requested on the fire safety training to verify compliance with MN Statute 144G.45 subd. 2(c), but one was not able to be provided.<br><br>A policy was requested on the evacuation training to verify compliance with MN Statute 144G.45 subd. 2(f), but one was not able to be provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |

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| 0 980 | Continued From page 20 | 0 980 | | |
| 0 980 SS=F | 144G.51 ARBITRATION<br><br>(a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action.<br><br>(b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of law or choice of venue provision. The resident agreement included a waiver of trial by jury for R1. This had the potential to affect all one hundred forty-nine residents receiving assisted living services.<br><br>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).<br><br>The findings include:<br><br>R1's signed Residency Agreement dated October 22, 2021, Section V (Agreement to Arbitrate) indicated that "any and all claims or controversies | 0 980 | | |

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| 0 980 | Continued From page 21<br>arising out of your stay at the community shall be submitted to binding individual arbitrations and shall not be filed in a court of law". The Agreement also included, "The parties to this Agreement further understand that a judge and/or jury will not decide their case".<br><br>On November 9, 2021, at 2:30 p.m., licensed assisted living director (LALD)-A confirmed all resident agreements included an arbitration agreement that incorporated a choice of law and choice of venue provision.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 980 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the | 01440 | | |

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| 01440 | Continued From page 22<br>individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to document the direct supervision of unlicensed personnel (ULP) for two of three employees (ULP-D and ULP-G) reviewed.<br><br>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).<br><br>The findings include:<br><br>On November 9, 2021, at 7:05 a.m., ULP-D was observed to pass medications to one resident.<br><br>ULP-D had a hire date of July 7, 2015. ULP-D's employee record lacked documentation of direct supervision to verify that the work was being performed competently and to identify problems and solutions to address issues related to the staff's ability to provide the services since 2016. ULP-D had not had a performance review to evaluate performance until 2021.<br><br>On November 9, 2021, at 8:15 a.m., ULP-G was observed to pass medications to six residents. | 01440 | | |

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|---|---|---|---|---|
| 01440 | Continued From page 23<br><br>ULP-G had a hire date of September 14, 2016. ULP-G's employee record lacked documentation of direct supervision to verify that the work was being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services since 2016. ULP-G had not had a performance review to evaluate performance until 2021.<br><br>During an interview on November 9, 2021, at approximately 11:00 a.m., business office manager (BOM)-H stated if supervisory visits existed for ULP-D or ULP-G, they would be located in their employee files.<br><br>The licensee's policy titled Associate Supervision/Delegation MN-14, dated August 2021, indicated the direct supervision of staff performing delegated tasks should be performed within 30 days after the individual begins working for the community and thereafter as needed based on performance.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20381 | A. BUILDING: _____ B. WING _____ | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE EDINA | 3330 EDINBOROUGH WAY EDINA, MN 55435 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 24<br>reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medication was administered as prescribed for one of six residents (R5) with records reviewed.<br>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).<br>The findings include:<br>R5's medication was not administered as prescribed.<br>R5's diagnoses included dementia and hypertension.<br>R5's service plan dated, August 8, 2021, included medication administration.<br>R5's prescriber orders dated, July 27, 2020, indicated R5 was to receive Metoprolol 25 milligrams (mg) (a hypertensive medication) in the morning. The prescriber indicated not to give the medication if R5's heart rate was less than 60, and if R5's systolic blood pressure was less than 90.<br>On November 9, 2021, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-F, administer the prescribed metoprolol to R5. ULP-F did not obtain R5's heart rate and did not | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20381 | A. BUILDING: _____ B. WING _____ | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE EDINA | 3330 EDINBOROUGH WAY EDINA, MN 55435 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 25<br>obtain R5's systolic blood pressure prior to administering the medication.<br>On November 9, 2021, at 8:30 a.m., ULP-F stated she was busy and forgot to obtain R5's heart rate and systolic blood pressure prior to administering medication to R5.<br>The licensee's Medication and Treatment Administration policy dated, November 2018, indicated medication administration must be in accordance with the prescriber's orders.<br>No further information was provided.<br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01760 | | |
| 02040 SS=E | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>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:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide a hazard vulnerability assessment or safety risk of the physical environment specific to the facility. This had the potential to affect all dementia care residents, staff and visitors. | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20381 | A. BUILDING: _____ B. WING _____ | 11/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE EDINA | 3330 EDINBOROUGH WAY EDINA, MN 55435 |

| (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 26<br><br>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).<br><br>The findings include:<br><br>On November 9, 2021, between 10:00 a.m. and 10:35 a.m., dining services director (DSD)-I and maintenance director (DM)-J stated they were not aware of any sort of hazard vulnerability assessment outside of the items provided in Appendix Z.<br><br>The licensee lacked a record of a hazard vulnerability assessment for the physical environment on or around the property.<br><br>A policy was requested for the hazard vulnerability assessment, but was not provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040 | | |

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

Type: Full
Date: *11/08/21*
Time: 10:00:00
Report: 1013211300

# Food and Beverage Establishment Inspection Report



**Location:**
Brookdale Edina
3330 Edinborough Way
Edina, MN55435
Hennepin County, 27

**Establishment Info:**
ID #: 0038655
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9528314084
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.

**3-300B Protection from Contamination: cross-contamination, eggs**

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

READY-TO-EAT HAM WAS STORED DIRECTLY ON TOP OF A PACKAGE OF RAW GROUND BEEF LOCATED IN THE WALK-IN COOLER. THE HAM PACKAGE WAS OPEN AND STORED IN PLASTIC WRAP. COMPLY WITH ABOVE RULE. DISCUSSED PROPER FOOD STORAGE AND THE FOODS WERE REMOVED.

*Corrected on Site*

**4-700 Sanitizing Equipment and Utensils**

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

HOT WATER SANITIZING DISH MACHINE WAS USED IN THE MAIN KITCHEN. THE DISH MACHINE WAS IN USE AND MEASURED A MAXIMUM TEMP OF 128F AT THE WARE LEVEL. COMPLY WITH RULE. STAFF CONTACTED A TECH TO SERVICE THE MACHINE AND WASHED WARE AT 3-COMP SINK.

*Comply By: 11/08/21*

**4-300 Equipment Numbers and Capacities**

4-302.13B ** Priority 2 **

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

THE FACILITY HAS A HOT WATER SANITIZING DISH MACHINE IN THE MAIN KITCHEN. NO TEST KIT MEETING THE ABOVE REQUIREMENTS WAS AVAILABLE. COMPLY WITH ABOVE RULE.

*Comply By: 11/22/21*

**6-300 Physical Facility Numbers and Capacities**

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

THE PAPER TOWEL DISPENSER DID NOT WORK LOCATED AT THE HAND WASHING SINK IN THE FOURTH FLOOR MEMORY CARE KITCHEN. COMPLY WITH ABOVE RULE. REQUESTED STAFF STOCK PAPER TOWELS AND REPAIR THE DISPENSER.

*Comply By: 11/08/21*

**7-100 Toxic Labeling**

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

A SPRAY BOTTLE CONTAINING PEROXIDE CLEANER WITHOUT A LABEL (MAIN KITCHEN) AND A SPRAY BOTTLE WITH DILUTED CLEANER LABELED PEROXIDE CLEANER (4TH FLOOR KITCHEN) WERE OBSERVED. COMPLY WITH ABOVE RULE. DISCUSSED LABELING AND STAFF DISCARDED THE PRODUCTS.

*Corrected on Site*

**2-100 Supervision**

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM WAS EMPLOYED AT THE FACILITY. COMPLY WITH ABOVE RULE. THE MN CFPM INFORMATION WAS PROVIDED TO THE OPERATOR.

*Comply By: 02/08/22*

**2-400 Hygenic Practices**

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

NUMEROUS STAFF HAD PERSONAL DRINKS WITHOUT LIDS LOCATED IN THE MAIN KITCHEN. THE DRINKS WERE STORED ON SHELVES IN THE PREP AND WARE WASHING AREAS. COMPLY WITH ABOVE RULE. THE DRINKS WERE REMOVED AND WE DISCUSSED DESIGNATING AN AREA FOR DRINK STORAGE.

*Comply By: 11/08/21*

**4-600 Cleaning Equipment and Utensils**

4-602.11D5

MN Rule 4626.0845D5 Clean equipment used for the storage of packaged or unpackaged food, such as a reach-in refrigerator, at a frequency which precludes accumulation of soil residues.

FOOD DEBRIS WAS LOCATED INSIDE THE COLD DRAWERS ON THE COOK LINE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE. REVIEWED PROPER CLEANING PROCEDURES WITH STAFF.

*Comply By: 11/08/21*

**4-900 Protecting Clean Items**

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

ICE WANDS (STICKS) USED TO COOL LARGE BATCH FOODS WERE STORED ON THE FLOOR IN THE WALK-IN FREEZER. COMPLY WITH ABOVE RULE. DISCUSSED PROPER STORAGE OF CLEAN EQUIPMENT AND REQUESTED THE ICE WANDS BE CLEANED AND SANITIZED.

*Comply By: 11/08/21*

**5-200A Plumbing: approved materials/design**

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

THE MAIN KITCHEN HAND WASHING SINKS LOCATED IN THE FRONT EXPO AND BACK PREP AREAS WERE NOT WORKING. STAFF IDENTIFIED THE SINKS AS HAND WASHING SINKS. REPAIR OR REPLACE THE SINKS. COMPLY WITH ABOVE RULE. STAFF USED THE OTHER 3 HAND WASHING SINKS.

*Comply By: 11/11/21*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Expo Area
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Prep Area
Violation Issued: No

Hot Water: = at 128 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

**Food and Equipment Temperatures**

# Food and Beverage Establishment Inspection Report



Process/Item: Yogurt
Temperature: 40 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

Process/Item: Deli Salad
Temperature: 41 Degrees Fahrenheit - Location: 2-Door Cooler
Violation Issued: No

Process/Item: Burgers
Temperature: 38 Degrees Fahrenheit - Location: Cold Drawer
Violation Issued: No

Process/Item: Soups
Temperature: 149 Degrees Fahrenheit - Location: Tall Warmer
Violation Issued: No

Process/Item: Chicken Wild Rice Soup
Temperature: 164 Degrees Fahrenheit - Location: Soup Warmer
Violation Issued: No

Process/Item: Soup
Temperature: 37 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cheese
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Yogurt
Temperature: 40 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

Process/Item: Apple Sauce
Temperature: 40 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 2 | 3 | 5 |

The main kitchen, 4th floor memory care kitchen, and 3rd floor memory care kitchen were inspected.

Discussed serving highly susceptible populations, final cook temperatures, ware washing, cleaning, sanitizer use, staff illness policy, food storage, pest control, date marking, and food handling procedures.

# 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 1013211300 of 11/08/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

Sheila Brown
Operator

Signed: JM

Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us

Report #: 1013211300

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

**Minnesota Department of Health**
**Food, Pools, and Lodging Services**
**P.O. Box 64975**
**St. Paul, MN 55164-0975**

| | | | |
|---|---|---|---|
| **No. of RF/PHI Categories Out** | 5 | **Date** | 11/08/21 |
| **No. of Repeat RF/PHI Categories Out** | 0 | **Time In** | 10:00:00 |
| **Legal Authority MN Rules Chapter 4626** | | **Time Out** | |

| | **Address** | **City/State** | **Zip Code** | **Telephone** |
|---|---|---|---|---|
| Brookdale Edina | 3330 Edinborough Way | Edina, MN | 55435 | 9528314084 |

| **License/Permit #** | **Permit Holder** | **Purpose of Inspection** | **Est Type** | **Risk Category** |
|---|---|---|---|---|
| 0038655 | | 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 | X | |
| 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 | X | |
| | **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 | X | 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 | X | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| | | **Physical Facilities** | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | X | 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:** 11/08/21

Inspector (Signature) JM