

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 12, 2023

Licensee Emerald Crest of Minnetonka 13417 Lake Street Extension Minnetonka, MN 55305

RE: Project Number(s) SL20705015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 24, 2023, 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.

LICENSING ORDERS

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this evaluation of your facility.

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 evaluations. 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

Emerald Crest of Minnetonka April 12, 2023 Page 2

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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

State Rapid Response Team / State Evaluation Team

Health Regulation Division 85 East Seventh Place, Suite 220

P.O. Box 64970 / P.O. Box 3879

St. Paul, MN 55164-0970 / 55101-3879

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 651-215-6894 / 651-281-9796

ННН

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPLI	
			A. BOILDING.	·		
		20705	B. WING		03/24	/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	ΙΟΝΚΔ	KE STREET NKA, MN 5	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	In accordance with 144G.08 to 144G.9 issued pursuant to Determination of wirequires compliance provided at the Star When Minnesota Stailure to comply with considered lack of INITIAL COMMENT SL20705015 On March 21, 2023 Minnesota Department of Survey at the above correction orders as survey, there were	PROVIDER LICENSING DER(S) Minnesota Statutes, section 5, these correction orders are a survey. hether violations are corrected e with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance. TS: through March 23, 2023, the nent of Health conducted a e provider, and the following re issued. At the time of the twenty-nine active residents under the Assisted Living		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assit tag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Conplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TOUR SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATUTES. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1446 subd. 1, 2, and 3.	oftware. I to sted signed column Statute kt of the listed in iencies" s the ne state This as eyors' rrection. DING OF TO THIS ON FOR TATE	
0 480 SS=F	144G.41 Subd 1 (1 requirements (13) offer to provide	3) (i) (B) Minimum e or make available at least the	0 480	oubu. 1, 2, and 0.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20705	B. WING		03/2	4/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNET	IONKA	KE STREET NKA, MN 59	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 480	Continued From pa	ge 1	0 480			
		o residents: epared and served according ood Code, Minnesota Rules,				
	by: Based on observati review, the licensee prepared and serve Food Code. This ha	ent is not met as evidenced on, interview, and record e failed to ensure food was ed according to the Minnesota and the potential to affect all eisted Living Dementia Care				
	violation that did no safety but had the p resident's health or widespread scope (or represent a syste	ed in a level two violation (a t harm a resident's health or octential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	and Beverage Esta	included document titled, Food blishment Inspection Report, 23, for the specific Minnesota cies.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 780 SS=F	144G.45 Subd. 2 (a physical environme	ı) (1) Fire protection and nt	0 780			
		iving facility must comply with in Minnesota Rules, chapter				

Minnesota Department of Health

STATE FORM 6899 KH2N11 If continuation sheet 2 of 9

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20705	B. WING		03/2	4/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	ΓΩΝΚΑ	KE STREET NKA, MN 5	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 780	Continued From pa	ge 2	0 780			
	the State Fire Code (i) provide smoth for sleeping purpose (ii) provide smoth separate sleeping at of bedrooms; (iii) provide smoth separate sleeping at of bedrooms; (iii) provide smoth including crawled within a dwelling until including crawled (iv) where more required within an insleeping unit, interest that actuation of on the individual dwellif operate; and (v) ensure the smoke alarms comexcept that newly in	oke alarms in each room used				
	by: Based on observatifailed to provide sminterconnected so to causes all alarms in This deficient condistaff and residents. This practice result violation that did not safety but had the president's health or cause serious injury was issued at a wide problems are pervalent.	ent is not met as evidenced on and interview, the licensee noke alarms that are hat actuation of one alarm in the dwelling unit to actuate. Ition had the ability to affect all ed in a level two violation (and tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when asive or represent a systemic coted or has potential to affect				

Minnesota Department of Health

STATE FORM 6899 KH2N11 If continuation sheet 3 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20705	B. WING		03/2	4/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	ΓΟΝΚΑ	KE STREET NKA, MN 5!	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 780	Continued From pa	ge 3	0 780			
	a large portion or al	I of the residents).				
	Findings include:					
	survey staff toured Assisted Living Dire Environmental Serv of Safety (DOS)-E. observed that the sequipped with smolinterconnected with the dwelling unit, so would cause all alar interview, DOS-E or rooms were not the deficient condition were	, at approximately 10:00 a.m., the facility with the Licensed ector (LALD)-C, the Director of vices (MD)-D, and the director During the facility tour, it was leeping rooms that were see alarms were not the other smoke alarms in the actuation of one alarm rms to operate. During the confirmed that the sleeping fire- rated doors. This was visually verified by d DOS-E accompanying the				
	TIME PERIOD FOF days.	R CORRECTION: Seven (7)				
0 810 SS=F	144G.45 Subd. 2 (b physical environme	o)-(f) Fire protection and nt	0 810			
	maintain fire safety plans shall include (1) location and n rooms; (2) employee actionation after or similar emetal (3) fire protection residents; and (4) procedures for evacuation, or relocemergency including	iving facility shall develop and and evacuation plans. The but are not limited to: umber of resident sleeping ons to be taken in the event of ergency; procedures necessary for resident movement, cation during a fire or similar g the identification of unique needs for movement or				

Minnesota Department of Health

STATE FORM 6899 KH2N11 If continuation sheet 4 of 9

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20705	B. WING		03/2	4/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	I ()NK A	KE STREET NKA, MN 5	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 810	evacuation. (c) Employees of as receive training on plans upon hiring at thereafter. (d) Fire safety and creadily available at (e) Residents who at their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill eve the residents is not activation is not require.	esisted living facilities shall the fire safety and evacuation at least twice per year evacuation plans shall be all times within the facility. The are capable of assisting in a shall be trained on the ke in the event of a fire to evacuation, or relocation. The ade available to residents at are required for employees whift with at least one ry other month. Evacuation of required. Fire alarm system uired to initiate the evacuation	0 810			
	by: Based on observati review, the licensee and evacuation plan failed to conduct re- had the potential to visitors. This practice result- violation that did no safety but had the president 's health or cause serious injury was issued at a wid problems are perva	ent is not met as evidenced on, interview and record e failed to develop a fire safety in with required elements and quired evacuation drills. This affect all staff, residents, and ed in a level two violation (a tharm a resident's health or octential to have harmed a resafety, but was not likely to y, impairment, or death), and despread scope (when sive or represent a systemic cted or has potential to affect I of the residents).				

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		20705	B. WING		03/	24/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	IONKA	KE STREET			
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	ONKA, MN 5	PROVIDER'S PLAN OF CO	PRECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 5	0 810			
	Findings include:					
	documentation were 2023, at approxima Licensed Assisted L Director of Environr the Director of Safe and evacuation plan training for the facility evacuation drills for	•				
	indicated that the lid fire safety and evac Review of the availa	e available documentation censee did not maintain the cuation plan for the facility. The documentation and the nent provided by DOS-E ving discrepancies:				
	closed doors in a sa the fire alarm goes shelter-in-place poli observed that the re have fire-rated prote have any smoke co compartment doors - The policy states to	that all residents are behind are smoke compartment when off, and the facility has a cy. During the tour, it was esident's bedroom door did not ection, and the facility did not impartments or smoke to contain fire and smoke. That if in a hurry, use the each unit/department. But the an elevator.	t			
	indicated that the licevacuation drills eventuate. During the inthe licensee had conthe employees on 2 conducted any evacuation to meet the	e available documentation censee did not conduct ery other month as required by interview, LALD-C stated that inducted evacuation drills for 2/16/2023 but had not cuation drills prior to those minimum every other month onally, the drill was conducted	,			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20705	B. WING		03/2	4/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EMERAL	D CREST OF MINNE	ΙΟΝΚΔ	KE STREET NKA, MN 55	EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 810			0 810			
	provided for house LALD-C stated that	401), and no drill record was 2(13409) and house 3(13417). this was their only drills for all three buildings.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
01440 SS=F	144G.62 Subd. 4 S delegated nurs	upervision of staff providing	01440			
	therapy tasks must appropriate licenser registered nurse ac facility's policy when provided to verify the performed competer and solutions related to perform the tasks performing medicate administration shall nurse or appropriate and must include of administering the minteraction with the (b) The direct superdelegated tasks much calendar days after individual begins we performs the delegated requirement also apperformed delegated	be provided by a registered elicensed health professional beervation of the staff nedication or treatment and the resident. rvision of staff performing ast be provided within 30 the date on which the prking for the facility and first ated tasks for residents and ed based on performance. This oplies to staff who have not ed tasks for one year or longer.				
	by: Based on observati	ent is not met as evidenced on, interview, and record a failed to ensure a registered				

Minnesota Department of Health

STATE FORM 6899 KH2N11 If continuation sheet 7 of 9

PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 01440 Continued From page 7 nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an observation on March 21, 2023, at		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
CALL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TOTAL PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 101440 Continued From page 7 O1440 O			20705	B. WING		03/	24/2023
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O1440 Continued From page 7 nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an observation on March 21, 2023, at			TONKA 13417 LA	AKE STREET E	EXTENSION		
nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an observation on March 21, 2023, at	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE
12:15 p.m., ULP-F performed blood glucose monitoring and insulin administration to R1 as prescribed. ULP-F had a hire date of February 13, 2017. ULP-F was hired to provide direct care and services to the licensee's residents. ULP-F's employee record lacked documentation of an RN supervising ULP-F performing delegated tasks within 30 days of providing delegated services. During an interview on March 21, 2023, at 12:35 p.m., ULP-F stated a previous RN had completed training with ULP-F on blood glucose monitoring and insulin administration. ULP-F stated they could not remember if they had been supervised on completing the delegated tasks. During an interview on March 21, 2023, at 1:20 p.m., RN-A stated that the licensee did not conduct official 30-day supervisory evaluations of	01440	nurse (RN) conduct performing delegate providing services of personnel ((ULP)-F This practice result violation that did not safety but had the president's health or widespread scope or represent a system or has the potential of the residents). The findings included During an observat 12:15 p.m., ULP-F monitoring and insupprescribed. ULP-F had a hire dulled ULP-F was hired to services to the licer employee record la supervising ULP-F within 30 days of properties on completing the control of the completing the control of the completing an interview p.m., ULP-F stated training with ULP-F and insulin administ could not remember on completing the control of th	ted direct supervision of staffed tasks within 30 days of for one of one unlicensed.). ed in a level two violation (at harm a resident's health or potential to have harmed a safety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all estimates as a large portion or and estimates as a large portion of an estimate of February 13, 2017. In provide direct care and large is estimated as a provide delegated tasks a previous RN had completed on blood glucose monitoring tration. ULP-F stated they are if they had been supervised delegated tasks. on March 21, 2023, at 1:20 hat the licensee did not				

Minnesota Department of Health

STATE FORM 6899 KH2N11 If continuation sheet 8 of 9

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		20705	B. WING		03/2	24/2023
	PROVIDER OR SUPPLIER LD CREST OF MINNET	TONKA 13417 LA		STATE, ZIP CODE EXTENSION 5305		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01440	on and had included management plan. The licensee's Supplement Licensed Staff indicated supervision of delegated task(s) was and the control of the control	d it in their quality ervision of Unlicensed Staff policy dated August 2021, on of ULPs by an RN will be if the staff performing a within thirty (30) calendar days over begins working and first ated resident task. CORRECTION:	01440			

Minnesota Department of Health



625 Robert Street North St Paul 651-201-4500

Type: Full
Date: 03/21/23
Time: 12:09:56
Report: 7994231068

Food and Beverage Establishment Inspection Report

Page 1

Locat	

Emerald Crest Of Minnetonka 13417 Lake Street Extension Minnetonka, MN55305 Hennepin County, 27

License Categories:

Expires on: //

Establishment Info:

ID#: 0037687

Risk:

Announced Inspection: No

Operator:

Phone #: 9526987530

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.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER IN HOUSE 3 FOUND NOT CYCLING. STAFF INDICATED THE ISSUE STARTED THIS MORNING.

Comply By: 03/21/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HOUSE 2 DISHWASHER FOUND NOT DISPENSING SANITIZER

Comply By: 03/21/23

Total Orders In This Report Priority 1 Priority 2 Priority 3

0 0 2

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES: EGG SALAD 40 FRUIT 40 MILK 39 EGG SALAD 39

Page 2

Type: Full Date: 03/21/23 Time: 12:09:56 Report: 7994231068

Food and Beverage Establishment Inspection Report

Emerald Crest Of Minnetonka

MILK 38

SANITIZERS:

HOUSE 1 - NOT ABLE TO CYCLE DISHWASHER

HOUSE 2 - NOT DISPENSING SANITZIER

HOUSE 3 - 160 F

**KITCHEN IS PARTIALLY RESIDENTIAL WITH WOOD CABINETS AND MICA COUNTER TOPS. IF DAMAGE OCCURS PLEASE CONTACT INSPECTOR FOR ASSISTANCE TO BRINING FACILITY FULLY UP TO CODE. SOME OF THE WOOD CABINETS AND COUNTER TOPS ARE STARTING TO WEAR/CRACK **

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 7994231068 of 03/21/23.

Certified Food Protection Manager:			
Certification Number:	Expires: _	/ /	
Inspection report reviewed with person	in charge	and emailed.	
Signed:		Signed: Capital	Eha
Establishment Representative		Crystal Elva	
		Public Health S	anitarian 3

St Paul

651-201-3981

Crystal.Elva@state.mn.us

	Minnesota Depa	Food Establis						Categories C		0	Date (3/21
	•			\vdash				RF/PHI Cate			Time In	
DEPARTMENT OF HEALTH	625 Robert Stree St Paul	et North								Time Out		
Emerald Crest Of Min	nnetonka	Address				y/Stat			Zip Code		phone	
License/Permit #		13417 Lake Street Extension Permit Holder					of Inspection	on	55305 Est Type	952	6987530 Risk Catego	orv
0037687					Fu	•			200.1960		I mon ourog	,
	FOOD	BORNE ILLNESS RISK FAC	TOF	RS A	ND F	PUBL	IC HEALT	TH INTERV	ENTIONS			
		atus (IN, OUT, N/O, N/A) for each numbered							"X" in appropriate box			
IN= in compliance	OUT= not in cor	mpliance N/O= not observed		1/A= n	ot applic				site during inspection	1	R= repeat	/iolatic
Compliance St	tatus		cos	R		Com	pliance Sta					C
INOUT	DIC knowledged	Surpervision	Т		40	111 0	LIT NUA NUO		nperature Contro		ntety	
I (IN)OUT 2 (IN)OUT N/A		ole; duties & oversight otection manager, duties		\vdash			$\overline{}$	1	ng time & tempera		aldia a	+
2 (110)001 14//	·	Employee Health			19 20		$\overline{}$		ating procedures for ng time & tempera		olaing	+
B(IN) OUT		ledge,responsibilities&reporting			21		$\overline{}$					
4 (IN) OUT	-	porting, restriction & exclusion		\vdash	220	$\overline{}$	UT N/A) N/O		olding temperature			+
	· ·	esponding to vomiting & diarrheal			\rightarrow	\sim		<u> </u>	nolding temperatur			_
OUT OUT	events				23(-		· .	marking & disposit		duras 0 - '	+
6 (IN) OUT		Hygenic Practices			24	ич О	U (N/A) N/O		iblic health control	. proced	uures & record	>
\sim		sting, drinking, or tobacco use		\vdash	25	IN! O	LIT NIA		nsumer Advisory dvisory provided fo	or row/··	indercooked to	od
(IN) OUT N/C	· 1	m eyes, nose, & mouth			25	IN C	UT(N/A)		usceptible Popula		inaercookea fo	ou
8 IN OUT A	Preventing (Contamination by Hands			26(IN)	UT N/A		foods used: prohib		nds not offered	
8 IN) OUT N/C	- '	ontact with RTE foods or pre-approved	\vdash	\dashv	290	- ر			olor Additives an			
9 (IN) OUT N/A N/O		dure properly followed			27	IN O	UT(N/A)	1	es: approved & pro			
IO(IN)OUT		vashing sinks supplied/accessible			—	ÎN)O	$\overline{}$		nces properly ider			
		proved Source							e with Approved		<u>`</u>	
IN OUT	Food obtained from	om approved source			29	IN O	UT(N/A)	Compliance	with variance/spec	ialized	process/HACC	P
2 IN OUT N/A(N/C	Food received at	proper temperature						-				_
I3(IN) OUT	Food in good cor	ndition, safe, & unadulterated										
	Required records	s available; shellstock tags,	-									
14 IN OUT N/A N/C					Risl	c facto	rs(RF) are in	mproper practi	ces or proceedure	s identi	fied as the mos	st
110 00 1007 100	Protection f	ion from Contamination			prev	alent o	contributing fa	actors of foodb	orne ilİness or inju	ıry. Pub	lic Health Inte	st erven
110 00 1007 100	parasite destructi	ion from Contamination			prev	alent o	contributing fa	actors of foodb	ces or proceedure porne illness or inju t foodborne illness	ıry. Pub	lic Health Inte	st erven
110 00 1007 100	Protection f Food separated	ion from Contamination			prev	alent o	contributing fa	actors of foodb	orne ilİness or inju	ıry. Pub	lic Health Inte	st erven
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IN OUT N/A N/A	Protection to Food contact sur	from Contamination and protected faces: cleaned & sanitized n of returned, previously served, unsafe food	DD R	RETA	prev (PH	ralent o	contributing fa	actors of foodb	orne ilİness or inju	ıry. Pub	lic Health Inte	st erven
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