DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2025

Licensee
The Waters Of Excelsior
723 Water Street
Excelsior, MN 55331

RE: Project Number(s) SL34114016

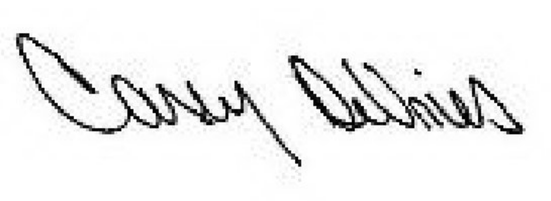
Dear Licensee:

On January 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 24, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Electronically Delivered

December 30, 2024

Licensee
The Waters Of Excelsior
723 Water Street
Excelsior, MN 55331

RE: Project Number(s) SL34114016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

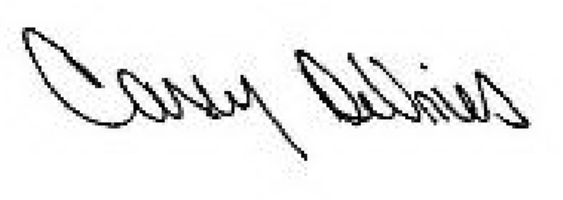
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34114	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EXCELSIOR	723 WATER STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34114016-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 130 residents, 50 of whom received services under the Assisted Living with Dementia Care license. An immediate correction order was identified on October 21, 2024, issued for SL34114016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on October 23, 2024, issued for SL34114016-0, tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	0 480		

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0 480	Continued From page 2 storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 3 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to medication administration for one of two unlicensed personnel (ULP-A). 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 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on April 30, 2021, to provide assisted living services to residents. On October 22, 2024, from 8:06 a.m., during medication pass observation, the surveyor observed ULP-A sanitize their hands, and then prepare medications for administration to R5. During medication administration, the surveyor observed R5 drop a half pill on the floor. ULP-A picked the pill up from the floor and put it in R5's hand. The surveyor asked the ULP if it was ok to give a pill which was dropped on the floor. ULP-A took it from the resident's hand and stated they would call the nurse for direction. ULP-A went back to the medication cart and called the nurse. Then, ULP-A put the medication in an envelope and put it in the medication cart; ULP-A signed out another Oxycodone 2.5mg, half tablet, and administered it to R5. On October 23, 2024, at approximately 2:10 p.m., ULP-A stated when a pill is dropped to the floor, they usually pick the pill off the floor and call the nurse for direction. ULP-A stated "I saw it on the chair first and then I saw it on the floor. It was a split second, and I thought it was ok. I thought I could save it." On October 24, 2024, at approximately 10:57 a.m., clinical nurse supervisor (CNS)-C stated it	0 510		

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0 510	Continued From page 5 was not appropriate to administer a medication that was dropped to the floor, it was unsanitary and not safe for the resident. The licensee's Infection Control Plan policy last reviewed August 12, 2021, indicated "POLICY: [licensee's name] Infection Control plan includes infection control information that is designed to provide a safe and sanitary environment for residents, team members and visitors as well as to improve and reduce the overall infection rate within the community. It provides nursing professionals with criteria for appropriately identifying, reacting and treating infections within the community. " No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 6 reviews that identify areas of improvement needed and training needs; (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 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (registered nurse (RN)-H) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Assisted Living Staff Roster indicated RN-H was hired on January 16, 2024. RN-H provided supervision to staff and direct care services to residents. RN-H's employee file lack the following content; - copy of the registered nurse license; and - current job description. On October 22, 2024, at 12:35 p.m., licensed assisted living director (LALD)-D stated the current nursing license, and the current job	0 650		

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0 650	Continued From page 7 description were not kept in RN-H's employee record, and it was an oversight from the previous business office manager. The licensee's employee record policy dated March 4, 2019, indicated "The employee record shall include at a minimum the following: A written job description including duties, responsibilities, and qualification of the employee. Beginning date of employment. Educational qualifications for executive directors. A completed caregiver background check. Documentation of training or exemption verification." The licensee's policy did not indicate the employee record must include the following: - current professional license/registration/certification; - performance review; - annual training records; - infection control training; and - orientation records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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	0 680		

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0 680	Continued From page 8 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (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. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness	0 680		

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0 680	Continued From page 9 plan dated August 1, 2021, and last reviewed September 26, 2023, lacked evidence of the following required content: - annual review of the EPP; and - quarterly review of missing resident policy. On October 22, 2024, at 9:42 a.m., licensed assisted living director (LALD)-D stated the EPP is reviewed every year, and they did not do the review for this year yet. LALD-D also stated they did not do quarterly review of the missing resident policy. On October 22, 2024, at 9:44 a.m., regional nurse (R/RN)-J stated, "we are missing the annual policy review". The licensee's Disaster Planning and Emergency Preparedness Plan policy dated April 2022, indicated, "Purpose: To ensure compliance with state and federal regulation regarding disaster planning and emergency preparedness planning. Policy: [Licensee's name] will have a written 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. Procedure: [Licensee's name] will: o Post an emergency disaster plan prominently; o Provide building emergency exit diagrams to all residents; o Post emergency exit diagrams on each floor; o Have a written policy and procedure regarding missing residents. o Provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter	0 680		

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0 680	Continued From page 10 o Make emergency and disaster training annually available to all residents. o Ensure staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. o Meet any additional requirements adopted in rule." The licensee's Missing Resident/Elopement Plan last revised on august 7, 2021, indicated, "The Assisted Living Director and Director of Health and Wellbeing or clinical nurse supervisor will review the missing resident plan quarterly and document any changes to the plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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THE WATERS OF EXCELSIOR	723 WATER STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents as required by MN Statute 144G.45 Subd.2 (a)(4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all of the residents). The findings include: On October 22, 2024, at 8:00 a.m., during medication pass observation, the surveyor observed a broken key lock on the kitchen cabinet door under the sink in the specialty care unit where residents who required memory care assistance resided. The surveyor opened the cabinet and observed chemical detergents in the cabinet. Unlicensed personnel (ULP)-A stated the key was broken but the cabinet was supposed to be locked. On October 23, 2024, at approximately 8:00 a.m., the surveyor observed the kitchen cabinet door lock was not repaired and there was no detergent in the cabinet with a broken lock; the cabinet was empty. On October 24, 2024, at 10:05 a.m., the surveyor observed the kitchen cabinet door lock was not repaired, however observed the following detergents in the cabinet with the broken lock: - Odoban disinfectant laundry & air freshener;	0 800		

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0 800	Continued From page 12 - Diversey, Virex plus Plus, One-Step Disinfectant, Cleaner & Deodorizer (keep out of reach of children); - Dawn Professional manual Pot & Pan Detergent; - Comet with Bleach; - Bar Keepers Friend Cleanser; - Purell Health Soap; - Softsoap soothing clean; and - Fabulose Multi-Purpose cleaner. On October 24, 2024, at approximately 10:20 a.m., the surveyor observed two residents R6 and R7 wandering in the kitchen area. Registered nurse (RN)-H stated both R6 and R7 wandered aimlessly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil	01290		

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01290	Continued From page 13 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for three of 62 employees (concierge (CO)-E, server-F, and active life coordinator (ALC)-G). This had the potential to affect all residents living in the assisted living facility. This resulted in an immediate correction order on October 21, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Server-F Server-F was hired on October 23, 2019, to provide direct cares and services to residents. The licensee's Dining Room Server Schedule from October 20, through November 2, 2024, indicated server-F was scheduled to work second shifts (11:00 a.m. to close) October 22 through October 26, 2024, and October 29 through November 2, 2024.	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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01290	Continued From page 14 The licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) roster did not include Server-F in the list of employees whose BGS were affiliated to the licensee's HFID 34114. On October 21, 2024, the NETStudy 2.0 website indicated Server-F was separated from HFID 34114 on November 21, 2021. CO-E CO-E was hired on November 30, 2023, to provide direct care and services to residents. The licensee's Concierge Schedule from September 29, through November 9, 2024, indicated CO-E was scheduled to work second shifts (4:00 p.m. to 7:00 p.m.) October 2, 9, 12 13,16, 23, 25, 26, 30 and November 6 & 9, 2024. The licensee's NETStudy 2.0 roster did not include CO-E in the list of employees whose BGS was affiliated to the licensee's HFID 34114. On October 21, 2024, the NETStudy 2.0 website indicated CO-E was separated from HFID 34114 on April 30, 2024. ALC-G ALC-G was hired on January 16, 2020, to provide direct care and services to residents. The licensee's Concierge Schedule from September 29, through November 9, 2024, indicated CO-E was scheduled to work second shifts (4:00 p.m. to 7:00 p.m.) October 2, 9, 12 13,16, 23, 25, 26, 30 and November 6 & 9, 2024. The licensee's NETStudy 2.0 roster did not	01290		

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01290	Continued From page 15 include ALC-G in the list of employees whose BGS was affiliated to the licensee's HFID 34114. On October 21, 2024, the NETStudy 2.0 website indicated ALC-G was separated from HFID 34114 on the following dates: - November 21, 2021; - June 22, 2023; - July 12, 2023; and - October 1, 2023. On October 21, 2024, at 1:51 p.m., licensed assisted living director (LALD)-D stated ALC-F works six hours on every Thursday and Friday. On October 21, 2024, at 1:53 p.m., LALD-D stated there was a change in licensee's license number in November 2021, and every employee was resubmitted for BGS at that time. Certain individuals were timed out of going to get fingerprinted; net study terminated them from the system and they needed to be reinitiated for BGS. The surveyor inquired if the reinitiation was done. LALD stated they were not sure what had happened back then and, "It is now on my radar to check and make sure it is done." The licensee's Background Studies Policy dated July 12, 2021, read, "Procedure: Human Resources, or designee, will begin the background screening process once a conditional job offer has been accepted. All potential Team Members will complete an appropriate authorization form. Once obtained, the designee will initiate the screening process. *MN Communities Only Once the NetStudy Process has begun, an applicant can begin training once the study indicated "In Process" and is given a "No Supervision	01290		

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01290	Continued From page 16 Required" status. Employment will be provisional based off of the final determination. If a final determination returns with Immediate Removal, the Team Member must be immediately removed from any further employment. The Team Member will be advised of their right to appeal the decision with the MN Department of Human Services and will be placed on 30 day Administrative Leave. If the appeal is not filed, the appeal is denied, or the appeals process is not completed within the 30 day administrative leave, the Team Member's employment will be separated with [the licensee's name]. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 17 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessments and reassessments, not to exceed 90 calendar days from the last date of the assessment for three of five residents (R1, R2, R4). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included Parkinson's disease, personal history of malignant neoplasm of breast, and hyperlipidemia. R1's signed service agreement dated, April 9,	01620		

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01620	Continued From page 18 2024, indicated R1 received assistance with medication management, bathing, dressing, grooming, bed making, escort, ambulation, transfer, laundry services, and safety/security checks. R1's record included 90-day nursing assessments dated April 22, 2024, July 15, 2024, and October 15, 2024. The assessment completed on October 15, 2024, was 2 days past the 90-calendar day requirement. R2 R2's diagnoses included actinic keratosis, anxiety disorder, unsteadiness on feet, diastolic dysfunction, osteoarthritis, subdural hemorrhage, hypothyroidism, memory lapse or loss, and osteoporosis. R2's signed service agreement dated April 1, 2024, indicated R2 received assistance with bathing and dressing. R2's record included 90-day nursing assessments dated March 8, 2024, June 10, 2024, and September 5, 2024. The assessment completed on June 10, 2024, was 4 days past the 90-calendar day requirement. R4 R4's diagnoses included nonrheumatic mitral valve insufficiency, hypertension, venous insufficiency, and prediabetic. R4's signed service agreement dated April 1, 2024, indicated R4 received assistance with bathing, vital monitoring, and safety checks. R4's record included 90-day nursing assessments dated January 17, 2024, April 15,	01620		

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01620	Continued From page 19 2024, July 11, 2024, and October 23, 2024. The assessment completed on October 23, 2024, during the survey, was due to be completed by October 9, 2024. On October 24, 2024, at 10:47 a.m., regional nurse (R/RN)-J stated staff attempted to complete R4's 90-day assessment on October 10, 2024, and the resident declined. On October 24, 2024, at approximately 9:25 a.m., clinical nurse supervisor (CNS)-C provided the surveyor with the following progress notes written on October 10, 2024, and on October 14, 2024: - on October 10, 2024, at 11:25 a.m., a progress note written by RN-J indicated, "Writer attempted to complete 90 day assessment this morning. Resident did not answer cell phone and when writer knocked on [R4's] door, no answer. Will attempt again this afternoon." - On October 14, 2024, at 3:05 p.m., a progress note written by RN-J indicated, "Resident is going out of town this week and requested that we do [R4's] 90-day assessment on [R4's] return, 10/23 at 11:00AM." The progress note written on October 10, 2024, indicated the first attempt to complete the 90-day assessment was one day after the due date of October 9, 2024. On October 24, 2024, at 10:50 a.m., CNS-C stated they do their best to get assessments done by the due date but sometimes there were acute needs they had to attend to. The licensee's Comprehensive Resident Assessment, Monitoring and Reassessment policy last reviewed on July 19, 2021, indicated resident's ongoing health and wellbeing	01620		

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01620	Continued From page 20 reassessment and monitoring must be conducted by an RN and cannot exceed 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medication was administered as prescribed for one of three residents (R5). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number	01760		

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01760	Continued From page 21 of staff are involved, or the situation has occurred only occasionally). The findings include: R5 was admitted to the licensee on June 21, 2022, and started receiving assisted living services. R5's Service Agreement signed September 6, 2024, indicated R5 resided in memory care and received assistance with bathing, grooming, dressing, medication administration, and toileting. R5's Medication Administration Record (MAR) dated October 1, 2024, through October 22, 2024, included Oxycodone 5 milligram (mg) tablet, take one tablet by mouth twice a day for pain. On October 22, 2024, at 8:06 a.m., during medication pass observation, the surveyor observed unlicensed personnel (ULP)-A sanitize their hands and prepare medications for administration to R5. ULP-A signed into Eldermark(electronic medical record system). The surveyor observed R5's electronic medication administration record (MAR) indicated oxycodone 5mg tablet, take 1 tablet by mouth twice a day for pain. ULP-A opened the narcotic box and took out a medication card for oxycodone. The order on the card indicated oxycodone 5mg tablet, take ½ tab (2.5mg) by mouth every six hours as needed for pain. The surveyor also observed a sticker on the medication card that read "direction changed refer to chart". ULP-A then got the logbook and signed out oxycodone 5mg, then punched out one half tab (2.5mg) into a medication cup. ULP-A put the book and the medication card back	01760		

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01760	Continued From page 22 into the cart, locked it, and went to the dining room where R5 was sitting to administer the medication. The surveyor asked the ULP to double check the oxycodone order. ULP-A stated it was a new order. The surveyor asked what they should do when they had doubts about a medication order. ULP-A stated they should call the nurse and called the nurse for direction. ULP-A then stated the RN gave them direction to punch out two pills (of the 2.5mg). ULP-A punched out another pill and put it in the medication cup. ULP-A then signed out 2.5mg and corrected the previous log by adding two (2.) in front of the 5mg that they wrote previously to make it 2.5mg. On October 23, 2024, at 2:05 p.m., ULP-A stated it was a new order; the logbook indicated 5mg was given during the previous medication pass completed by another ULP, and stated that was why they got confused. On October 24, 2024, at 10:54 a.m., clinical nurse supervisor (CNS)-C stated they put a sticker on the medication card to alert staff of the medication order change when they receive new order. CNS-C also stated they did discuss changes to medication orders during their stand up meeting every day. CNS-C stated they retrain staff when there was medication error and stated ULP-A was retrained for the medication error discussed above. The licensee's Administration of Medication policy last reviewed on September 13, 2021, indicated, "Policy: To provide procedures for the direction and oversight regarding the safe, accurate, and timely administration of medications in correlation to statute regulation. To provide medication management services through development,	01760		

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01760	Continued From page 23 implementation and maintenance of current written medication management policies and procedures. The policies and procedures are developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of five residents (R1, R2) with consumer bed rails. This resulted in an immediate correction order on October 23, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	02310	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EXCELSIOR	723 WATER STREET EXCELSIOR, MN 55331

(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
02310	Continued From page 24 has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Parkinson's disease, personal history of malignant neoplasm of breast, and hyperlipidemia. R1's signed service agreement dated April 1, 2024, indicated R1 received services for assisting with medication management, bathing, dressing, grooming, bed making, escort, ambulation, transfer, laundry services, and safety/security checks. On October 22, 2024, at approximately 1:25 p.m., the surveyor observed a consumer bed rail on the right side of R1's hospital bed. R2 R2's diagnoses included actinic keratosis, anxiety disorder, unsteadiness on feet, diastolic dysfunction, osteoarthritis, subdural hemorrhage, hypothyroidism, memory lapse or loss, and osteoporosis. R2's unsigned service agreement dated October 23, 2024, indicated R2 received services for assisting with bathing and dressing. On October 23, 2024, at approximately 8:45 a.m., the surveyor observed a consumer bed rail on the left side of R2's bed. R1 and R2's record lacked the following documentation of assessments related to R1 and R2's use of the consumer bed rails: -Purpose and intention of the bed rail;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34114	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EXCELSIOR	723 WATER STREET EXCELSIOR, MN 55331

(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
02310	Continued From page 25 -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R1 and R2's record also lacked documentation the licensee checked the consumer product safety commission recall list to make sure there were no active recalls on the bed rails. On October 23, 2024, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-C stated they were not aware of R2's bed rail use, it was put on last month without their knowledge. CNS-C stated, "We went in and removed it." On October 23, 2024, at approximately 11:00 a.m., CNS-C provided the surveyor with a bed rail assessment for R1 which was completed during the survey (October 23, 2024). CNS-C stated they were not aware of R1's bed rail use until this morning. On October 23, 2024, at approximately 12:32 p.m., the surveyor inquired if an assessment was completed for R2 before removing the bed rail. CNS-C stated they removed the bed rail, and they did not complete any assessment for R2 before removing the bed rail. On October 23, 2024, at 1:38 p.m., CNS-C stated	02310		

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	34114	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EXCELSIOR	723 WATER STREET EXCELSIOR, MN 55331

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02310	Continued From page 26 R2's bed rail was installed some time in the last two weeks. CNS-C stated the unlicensed personnel (ULPs) were trained to report when they saw bed rails, but nobody reported R1 or R2's bed rail use to nursing staff. On October 23, 2024, at 1:41 p.m., ULP-I stated they saw R2's bed rail about a month ago. ULP-I stated they were not aware they were supposed to report resident's bed rail use to nursing staff as residents in assisted living do their own thing. ULP-I also stated they did not report R2's bed rail use to the nursing staff. On October 23, 2024, at approximately 2:00 p.m., during an interview with the surveyor, R1 placed a phone call to their daughter to inquire when the bed rail was installed. R1 reported to the surveyor the bed rail was installed at the end of September 2023. On October 23, 2024, at 2:18 p.m., the surveyor observed R1's most recent 90-day assessment completed on October 15, 2024, by CNS-C. The assessment indicated R1 had "halo bed rail" documented under the Functional Capabilities section of the assessment. On October 23, 2024, at 2:29 p.m., CNS-C stated the last time they were in R1's room was on October 15, 2024. They stated thy did not recall seeing a bed rail, "I saw it this morning." The surveyor asked CNS-C to look at the assessment they completed dated October 15, 2024, where it indicated "halo bed rail". The surveyor inquired if CNS-C had seen the bed rail on the bed. CNS-C stated according to their assessment they did see it. The Food and Drug Administration's (FDA), A	02310		

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	34114	A. BUILDING: _____ B. WING _____	10/24/2024

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02310	Continued From page 27 Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail	02310		

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02310	Continued From page 28 should include, but is not limited to: Purpose and intention of the bed rail Measurements The resident's bed rail use/need assessment Risk vs. benefits discussion (individualized to each resident's risks) The resident's preferences Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subpart 2. Assessment tool elements B. (3) indicated a resident's mobility status must be assessed to include ambulation, transfers, and assistive devices. The licensee's Bed Rail and Assistive Devices Policy last revised on June 8, 2024, indicated " If the resident expresses the desire to use a device or a device is in use, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and /or upon discovery of a rail. The licensed nurse will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. Obtain physician order: If a nursing assessment suggests a benefit to bed rail use, the Waters nurse must contact the provider's office to obtain a physician order. a. Bed rail order must specify reasoning for use of assistive bed device as one of the following: i. To promote enhanced bed mobility ii. Resident fear of falling. b. Bed rail specifics must also be identified in the order.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 29 c. Example of appropriate bed rail order: Right half bed rail to promote enhanced bed mobility. d. Physician's orders for assistive devices must be renewed annually." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	02310		

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

Type: Full
Date: *10/21/24*
Time: 13:00:00
Report: 8041241209

Food and Beverage Establishment Inspection Report

Location:
The Waters Of Excelsior
723 Water Street
Excelsior, MN55331
Hennepin County, 27

Establishment Info:
ID #: 0039286
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522077220
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.

COOKED HAM STORED IN CONTAINER WITH UNPASTEURIZED SHELL EGGS IN WALK-IN COOLER. CORRECTED ON SITE. FOOD STORAGE TO PREVENT CROSS CONTAMINATION REVIEWED WITH PIC.

Comply By: 10/21/24

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

3-302.11A(2) ***** Priority 1 *****

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

PACKAGE OF RAW CHICKEN STORED ON PACKAGE OF RAW GROUND BEEF IN THE WALK-IN COOLER. CORRECTED ON SITE.

Comply By: 10/21/24

3-500B Microbial Control: hot and cold holding

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

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

BUTTER ON COUNTER MEASURED 80F. BUTTER IS A TCS FOOD AND MUST BE STORED USING MECHANICAL REFRIGERATION. DISCARDED.

Comply By: 10/21/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

ISSUED 6/1/23 (REPEAT 10/21/24): CAN OPENER BLADE HAS A BUILD-UP OF DRIED FOOD DEBRIS. CAN OPENER BROUGHT THE THE DISH AREA TO BE CLEANED.

Comply By: 10/21/24

5-200A Plumbing: approved materials/design

5-202.12A ***** Priority 2 *****

MN Rule 4626.1050A Provide a handwashing sink equipped with running water at a temperature to permit handwashing for at least 15 seconds through a mixing valve or combination faucet.

NO WATER AVAILABLE AT TIME OF INSPECTION DUE TO CONSTRUCTION AND PLANNED SHUT OFF. GRAVITY HANDWASHING STATIONS SET UP. SEE COMMENTS FOR DETAILS. CONFIRMATION THAT WATER WAS TURNED BACK ON IN THE AFTERNOON SENT TO INSPECTOR.

Comply By: 10/21/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

ACCUMULATION OF DUST AROUND THE CEILING VENTS IN THE KITCHEN.

Comply By: 10/28/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Receiving
Temperature: 41 Degrees Fahrenheit - Location: US FOODS: SPINACH
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER: HAM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER: ROAST BEEF
Violation Issued: No

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

Type: Full
Date: *10/21/24*
Time: 13:00:00
Report: 8041241209
The Waters Of Excelsior

Food and Beverage Establishment Inspection Report

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

Process/Item: Cold Holding
Temperature: 80 Degrees Fahrenheit - Location: COUNTER: BUTTER
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CAFE DISPLAY COOLER: MILK
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CAFE REACH-IN COOLER: MABIENT AIR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: GRILL DRAWER: CORNED BEEF
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: UPRIGHT/DESSERT COOLER: MILK
Violation Issued: No

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

Inspection was completed with Matthew Jacobsen. Dee Mosissa was the Health Regulation Division Nurse Evaluator on site completing site survey. This facility has a commercial kitchen and a cafe.

**The kitchen was not fully functional at time of inspection due to water shut off. There was construction in the area and there was a planned water shut. Kitchen had gravity handwashing stations set up and was doing minimal food prep. Sandwiches were prepared for dinner service with all disposable dishes/utensils. Water shut off occurred at 11am and was turned back on after 4pm.

Picture of test strip to measure the utensil surface temperature in the dish machine received.

Discussed the following:
- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Pest control
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

Type: Full
Date: *10/21/24*
Time: 13:00:00
Report: 8041241209
The Waters Of Excelsior

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 8041241209 of 10/21/24.

Certified Food Protection Manager: Matthew L. Jacobsen

Certification Number: fm63986 Expires: 12/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Matthew Jacobsen
Director of Culinary

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us