Electronically Delivered

March 7, 2025

Licensee
Mendota Heights WP, LLC
745 South Plaza Drive
Mendota Heights, MN 55120

RE: Project Number(s) SL29408016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 6, 2025, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

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

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.

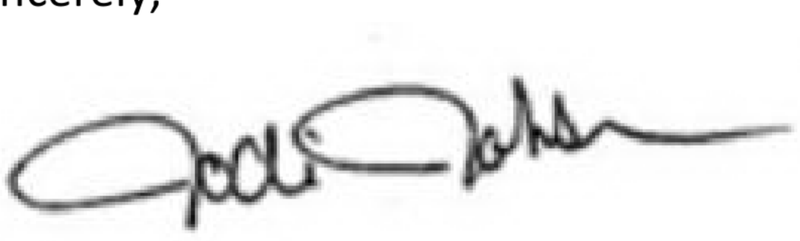
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29408016-0 On February 2, 2025, through February 6, 20245, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 39 residents; 39 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	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 complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by three of six employees (unlicensed personnel (ULP-I, ULP-J), and assisted living director in residency (ALDIR-A)) during personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 510	Continued From page 4 found to be pervasive). The findings include: On February 4, 2025, at 7:30 a.m., ULP-J and ULP-I were observed providing cares to R6. ULP-J and ULP-I each donned a pair of gloves and worked together to change R6's soiled incontinence brief and cleanse the brief area. During the brief change, ULP-I was observed to toss R6's soiled brief to the carpeted floor further stating he didn't know where the trash can was. ULP-J and ULP-I continued to dress R6, used the Hoyer lift to transfer R6 to the Broda chair (a specialized wheelchair), and ULP-J brushed R6's hair all while using the same gloves. On February 4, 2025, at 8:05 a.m., ALDIR-A was observed changing R1's incontinence brief. The surveyor observed ALDIR-A placing the soiled incontinence brief on the carpeted floor. ALDIR-A indicated she did not know where R1's trash can was. On February 4, 2025, at 8:15 a.m., ULP-J and ULP-I were observed working together to provide cares to R7 in her room. ULP-J and ULP-I each donned a pair of gloves and continued to change R7's soiled incontinence brief and tossed the soiled brief onto the carpeted floor, stating they were not sure where R7's trash can was. ULP-J and ULP-I continued to dress R7 and transfer R7 with a Hoyer lift to her wheelchair while using the same gloves. ULP-J then sprayed R7's hair with water from a spray bottle and brushed R7's hair while running her gloved hands through R7's hair several times. ULP-J used the same gloves she used to change R7's soiled brief. ULP-J, ULP-I, and ALDIR-A failed to ensure	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 510	Continued From page 5 proper infection control with placing soiled incontinence briefs on the floor and not in a proper trash receptacle. ULP-J and ULP-I failed to change their gloves, sanitize their hands and don clean gloves after providing incontinence brief changes and providing cares. On February 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated she expected all employees to place soiled incontinence briefs in trash cans. She stated the licensee has been having issues keeping trash cans in the residents' rooms and needed to figure out how to ensure there were proper trash receptacles in all resident rooms. Furthermore, CNS-B stated she expected all employees to change their gloves and sanitize their hands when providing direct cares and following handling soiled briefs. The licensee's Infection Control policy dated April 1, 2024, indicated [licensee's name] infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The licensee's Gloves policy dated April 1, 2024, indicated the following; 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. 6. Dispose used gloves in proper receptacle. 7. Rewash hands. No other information was provided.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 510	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 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 observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 680	Continued From page 7 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 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 the residents). The findings include: On February 6, 2025, at 11:45 a.m., the surveyor reviewed the contents of the licensee's EP plan. The EP plan was last reviewed on January 3, 2025. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.; and - a review of the licensee's missing resident procedure on a quarterly basis On February 6, 2025, at 11:45 a.m., corporate director of nursing (CDON)-K stated the licensee	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 680	Continued From page 8 had not completed any drills or emergency preparedness exercises as required. Furthermore, CDON-K stated she thought the Missing Resident policy/procedure was to be reviewed twice yearly and was not aware of the required quarterly review. The licensee's Emergency Preparedness Plan-Appendix Z compliance policy dated April 1, 2024, indicated Exercises and Drills - [licensee's name] will conduct, at minimum, two emergency preparedness drills every 12 months -these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise, or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement. The licensee's Missing Resident policy dated April 1, 2024, indicated [licensee's name] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 790	Continued From page 9 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: On February 3, 2025, from 11:48 a.m. to 3:05 p.m. the surveyor toured the facility with the facility maintenance supervisor (FMS)-C and regional maintenance supervisor (RMS)-D. It was observed that a fire extinguisher was absent from the laundry room, where door markings indicated an extinguisher was present. FMS-C and RMS-D stated that an extinguisher had been present recently, but they were unsure where the extinguisher had gone. FMS-C and RMS-D verified the findings and stated that they understood the requirements and would provide a replacement extinguisher.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 790	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at approximately 1:35 p.m., assisted living director in training (ALDIR)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP did not include any documentation of resident actions or procedures to take during an evacuation or documentation of resident training on the FSEP. The FSEP must include fire procedures for residents and training must be offered to residents capable of assisting in their own evacuation at least annually. The FSEP did not include identification of room numbers on any provided documents. The document Mendota Heights Exit Plan was	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
0 810	Continued From page 12 provided as part of the FSEP, but did not include room numbers or identification. The FSEP did not include any documentation of training for staff on the FSEP. Employees must receive training on the FSEP upon hire and at least twice per year thereafter. The ALDIR-A indicated that they did not have an established plan for providing training to staff, but that establishing regular training was a priority they were working to implement. During the record review and interview on February 3, 2025, ALDIR-A verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01640	Continued From page 13 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for one of seven residents (R1). 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: R1 began receiving services under the licensee's assisted living with dementia care license on January 2, 2025. On February 5, 2025, at 10:15 a.m., unlicensed personnel (ULP)-G was observed to complete R1's blood sugar check and administer an insulin injection. The surveyor noted R1 to be receiving oxygen via nasal canula at the flow rate of 3 liters/minute (Lpm). On February 5, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B provided the surveyor with	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01640	Continued From page 14 R1's Service Plan. R1's Service Plan was signed by R1's designated representative on February 5, 2025, and clinical nurse supervisor (CNS)-B on February 5, 2025, (same day as survey). The Service Plan indicated R1 received the services of hospice, bathing, dressing/grooming, feeding assistance, assist of two staff for Hoyer (mechanical lift) transfers, toileting and incontinence care assistance, and laundry. R1's Service Plan lacked the services of medication administration, oxygen, and blood sugar checks. The licensee failed to ensure R1's Service Plan was signed by R1 or R1's designated representative, nor by a facility representative within 14 days as required. On February 5, 2025, at 11:00 a.m., CNS-B stated R1's service plan had not yet been signed by R1 or R1's designated representative as R1 had been in the hospital twice since her admission to the facility and R1's designated representative had been out of town and unavailable. CNS-B further stated she had not documented any of this. CNS-B stated she created R1's Service Plan and had just signed R1's Service Plan "today" as the facility representative. The licensee's Service Plan policy dated April 8, 2024, indicated: 1. Within 14 days after the date that services are first provided to a resident, [licensee's name] will finalize a written service plan. 2. The service plan and any revisions shall include a signature or other authentication by [licensee's name] and by the resident, or resident's representative, documenting agreement on the services to be provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01640	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01650	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of seven residents (R1). 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: R1's diagnoses included congestive heart failure (CHF), hypertension, type 2 diabetes with insulin dependence, and hyperthyroidism. On February 5, 2025, at 10:15 a.m., unlicensed personnel (ULP)-G was observed to complete R1's blood sugar check and administer an insulin injection. The surveyor noted R1 to be receiving oxygen via nasal canula at the flow rate of three liters/minute (Lpm). On February 5, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B provided the surveyor with R1's Service Plan. R1's Service Plan was signed by R1's designated representative and by CNS-B on February 5, 2025, (same day as survey). The Service Plan indicated R1 received the services of hospice, bathing, dressing/grooming, feeding assistance, assist of two staff for Hoyer (mechanical lift) transfers, toileting and incontinence care assistance, and laundry.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01650	Continued From page 17 R1's Medication Administration Record (MAR) dated February 1, 2025, through February 4, 2025, indicated staff assisted with medication/treatment administration to include: - blood sugar checks three times daily - bowel monitoring - risperidone 37.5 milligram (mg) intramuscularly (injected into the muscle) every 14 days - Lispro insulin 100 units/milliliter (u/ml) given 2-10 units based on a sliding scale of R1's blood sugar level - ammonium lactate 12% cream, topically (applied to the skin), at bedtime - levothyroxine 25 micrograms (mcg), one tablet daily - Melatonin 3 mg, three tablets daily at bedtime for sleep - Senna 8.6 mg, one tablet orally for constipation - Trazodone 50 mg 0.5 tablet daily at bedtime for sleep - acetaminophen 325 mg two tablets every six hours as needed for mild pain - analgesic balm 15%, apply topically three times daily for pain - Bisacodyl 10 mg, one suppository given rectally daily as needed for constipation (given on third day without a bowel movement - Desitin 40% cream applied four times daily to buttocks or sacral area - hyoscyamine 0.125 mg tablet, one tablet under the tongue every two hours as needed for excessive secretions - Nystatin cream 100,000 units/gram give topically two times daily for fungal growth on skin - polyethylene glycol 17 grams mixed with eight ounces of fluid daily as needed for constipation - Lactulose 10 gm/15 ml, give 30 ml by mouth every day as needed for constipation - lorazepam 0.5 mg, give one tablet under the tongue every two hours as needed for anxiety,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01650	Continued From page 18 nausea and sleep - Morphine 5 mg, give one tablet by mouth every one hour as needed for pain and shortness of breath - risperidone 1 mg, give one tablet by mouth every eight hours as needed for agitation. R1's Task documentation dated January 2025, and February 1-4, 2025, indicated the licensee provided and documentation of the following services: - bathing assistance - dressing/grooming assistance - incontinence care - linen change - mobility assistance - toileting assistance - feeding assistance - resident meals - assistance of two for transfers R1's record lacked documentation of her supplemental oxygen. R1's Service Plan lacked the services of medication administration, oxygen, and blood sugar checks. On February 5, 2025, at 11:30 a.m., CNS-B stated she didn't realize the above listed services were missing from R1's Service Plan and needed to be manually entered. The licensee's Service Plan policy dated April 8, 2024, indicated within 14 days after the date that services are first provided to a resident, [licensee name] will finalize a written service plan. Additionally: -Services plans shall be revised, if needed, based on resident reassessments and monitoring.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01650	Continued From page 19 -Services plans shall include fees for the services indicated in the service plan. - [licensee name] shall provide information to the residents about any changes to the facility's fees for assisted living services, included with a change in fees is information how to contact the Office of Ombudsman for Long Term Care. Furthermore, the Service Plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01750	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin administration via a prefilled insulin pen was administered according to manufacturer instructions for two of three residents (R2, R1) with insulin administration. Furthermore, the licensee failed to provide direction for as needed (PRN) medication administration for two of three residents (R1, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: INSULIN ADMINISTRATION R2 R2's diagnoses included vascular dementia, type 2 diabetes, and gallbladder mass. R2's Service Plan dated January 30, 2025, indicated the service of medication administration. R2's provider's orders dated October 26, 2024, indicated Aspart insulin 100 milligrams/milliliter (mg/ml), inject 1-7 units (u) using sliding scale dosing (the number of units is based on the blood sugar level at that time), given subcutaneously	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01750	Continued From page 21 (under the skin), twice daily (before breakfast and dinner) for diabetes. On February 4, 2025, at 9:49 a.m., unlicensed personnel (ULP)-G was observed to set up and administer R2's oral medications. ULP-G then completed and blood sugar check via finger stick. ULP-G prepared R2's insulin pen for insulin administration. ULP-G removed the protective cap from the insulin pen tip and connected a clean needle tip to the insulin pen without first cleansing the insulin pen rubber tip with an alcohol wipe. ULP-G then primed the insulin pen with the accurate amount of 2 units of insulin and set the appropriate dose (1 unit) per R2's sliding insulin scale (an insulin dose based on R2's blood sugar level at that time). ULP-G cleansed an area of skin on R2's lower right abdomen and administered the insulin. ULP-G referenced the electronic medication administration record (EMAR) on a computer/tablet. R1 R1's diagnoses included congestive heart failure (CHF), hypertension, and type 2 diabetes. R1's Service Plan dated February 5, 2025, (during time of survey), lacked the service of medication administration. R1's signed prescriber's orders dated January 27, 2024, indicated Lispro insulin, inject 2-10 units twice daily (11 a.m., 4 p.m.) per insulin sliding scale dosing for type 2 diabetes. On February 4, 2025, at 10:45 a.m., ULP-G was observed to complete a blood sugar check on R1. ULP-G then prepared R1's insulin pen for insulin administration. ULP-G removed the insulin pen's protective cap and attached a clean needle to the	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01750	Continued From page 22 insulin pen tip without first wiping the insulin pen rubber tip with an alcohol wipe. ULP-G then primed the insulin pen with 2 units of insulin and then set R1's sliding scale dosing (4 units) and provided the insulin injection per R1's preference of the upper right arm. ULP-G referenced the EMAR for the appropriate steps and dosing for R1's insulin. The surveyor noted both R2 and R1's EMAR included a step by step set of instructions for insulin pen preparation and administration. The step by step set up instructions included the step of cleansing the rubber tip of the insulin pen with an alcohol wipe prior to attaching a new needle. On February 4, 2025, at 10:50 a.m., ULP-G stated she was aware of the need to wipe the insulin pen rubber tip but had forgotten to do so. On February 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to follow the instructions as written out in the EMAR and to follow how the ULP were trained to properly prepare the resident's insulin pens. CNS-B stated she would provide an educational review of the proper procedure. PRN MEDICATION DIRECTION R1 R1's EMAR dated February 2025, indicated she received one injectable medication for diabetes, one injectable medication for schizophrenia, one oral thyroid medication, two for sleep, three oral medications for constipation, one for mild pain, one for excessive secretions, one for anxiety, one for agitation, one for severe pain or shortness of breath, one topical (on the skin) for pain, one for	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01750	Continued From page 23 skin protection, one suppository for constipation, and one antifungal powder. R1's signed prescriber's orders dated January 10, 2025, indicated: -Lactulose 10 grams (gm)/15 milliliters (ml), give 30 ml daily as needed for constipation; -polyethylene glycol 17 gm mixed with 6-8 ounces fluids daily as needed for constipation; -Senna 8.6 milligram (mg), give two tablets orally twice daily as needed for constipation; and -Bisacodyl 10 mg suppository, give one suppository daily as needed for constipation. The licensee failed to clarify which medication should be used first, second, third, or fourth to manage constipation. R1's signed prescriber's orders dated January 27, 2025, indicated: -risperidone 1 mg orally every eight hours as needed for agitation -lorazepam 0.5 mg, give one tablet orally every two hours as needed for anxiety, nausea, and sleep The licensee failed to clarify R1's symptoms of agitation and anxiety and which PRN medication should be administered first or second by the ULP. R6 R6's diagnoses included dementia, depression, and anxiety. R6's Service Plan dated July 26, 2024, included the service of medication administration. R6's EMAR dated February 2025, included one skin cream, one medication for pain/shortness of breath, one for bowel management, one eye drop for glaucoma (increased eye pressure), one for	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01750	Continued From page 24 excessive fluids, one supplement, and one antibiotic for skin infection. R6's PRN medications included two for anxiety/agitation, one for pain/shortness of breath, one for mild pain, one for excessive secretions, and one antifungal topical (skin) medication. R6's signed prescriber orders dated October 24, 2024, indicated: -lorazepam 0.5 mg, give one tablet every four hours as needed for anxiety or agitation; and -haloperidol 0.5 mg, give one tablet twice daily as needed for agitation. The licensee failed to clarify R6's symptoms of anxiety or agitation and failed to indicate which medication should be used first and second by the ULP. On February 5, 2025, at 11:45 a.m., CNS-B stated there was not clear direction for either resident regarding the PRN medications to manage symptoms of constipation or anxiety/agitation and would need to clarify these or indicate the ULP would need to call nursing for further direction. The licensee's Medication Administration policy dated April 1, 2024, indicated the ULP will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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	01760		
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 medications were administered as ordered for one of nine residents (R6) receiving medication services. 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: R6 began receiving services under the facility's Assisted Living Facility with Dementia Care license on May 31, 2022.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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 26 R6's diagnoses included dementia, depression, and anxiety. R6's Service Plan dated July 26, 2024, included the service of medication administration. On February 4, 2025, at 7:15 a.m., unlicensed personnel (ULP)-G was observed to take R6's box of diclofenac gel to her room. The diclofenac gel had not yet been opened. ULP-G opened it, dated the package with an open date, squeezed an undetermined amount of medication onto her gloved index finger and then applied to both of R6's knees. ULP-G failed to use the designated measuring tool to accurately measure the prescribed amount/dose of medication for R6. ULP-G stated she usually used a measuring tool to ensure an accurate dose but could not find the tool. The surveyor noted the measuring tool was in the box storing the diclofenac gel. ULP-G stated she did not see it. R6's signed prescriber orders dated October 24, 2024, indicated diclofenac 1% gel, 4 grams (gm) applied to both knees twice daily for pain. R6's electronic medication administration record (EMAR) indicated diclofenac 1% gel, apply 4 gm to both knees twice daily. Furthermore, the EMAR included step by step directions for the ULP to follow which included: -use the enclosed dosing card to measure the correct dose -the gel should be applied within the oblong area of the dosing card up to the 2 gm or 4 gm dosing line. 2 gm for elbow, wrist or hand, and 4 gm for knee, ankle and foot. ULP-G referenced R6's EMAR to determine the proper dosing prior to administration of this	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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 27 medication. On February 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to use the designated measuring tool to ensure medications were administered as ordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date for four of eight residents (R1, R2, R4, R5) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 28 found to be pervasive). The findings included: R1 R1's Service Plan dated February 5, 2025, (during time of survey), lacked the service of medication administration. On February 3, 2025, at 2:00 p.m., the surveyor and unlicensed personnel (ULP)-E reviewed the medications stored in one of two medication carts. The surveyor noted R1's section of the cart had the following insulin pens available for use: - glargine insulin 100 units/milliliter (u/ml) give 24 units daily at bedtime - lispro insulin Flex Pen- 100 u/ml, give 2-10 units per sliding scale Neither included an open date. ULP-E stated she was not aware of when either pen was opened/put into use. R1's signed prescriber's orders indicated: - January 27, 2025, Lispro insulin 100 u/ml, inject 2-10 units twice daily (11 a.m., 4 p.m.) per insulin sliding scale dosing for type 2 diabetes; - January 24, 2025, discontinue glargine insulin, 24 units injected daily at bedtime R1's insulin Flex Pens did not include an open date and failed to remove an insulin that had been discontinued. R2 R2's Service Plan dated January 30, 2025, indicated the service of medication administration. On February 3, 2025, at 2:00 p.m., the surveyor and ULP-E reviewed the medications stored in	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 29 one of two medication carts. R2's section of the medication cart included two Aspart insulin Flex Pens. One pen was in a zip lock bag and was dated October 9, 2024, and the other was undated. ULP-E stated she did not know when the insulin pen was opened. ULP-E stated the ULP know to write an open date for all insulin pens once they are moved from the refrigerator to the medication cart. On February 4, 2025, at 9:20 a.m., the surveyor observed ULP-G set up R2's morning medications. During the process of medication set up, ULP-G pulled out R2's Aspart insulin Flex Pen and began preparing the needle tip and primed with two units of insulin (this is the same pen noted without an open date the surveyor noted from the previous day's medication cart review). The surveyor shared with ULP-G that this pen and another Aspart insulin pen (dated October 9, 2024) remained in the medication cart and did not have an open date. ULP-G stated she could not use the pen then and pulled both from the medication cart and obtained a new Aspart insulin pen from the medication refrigerator located in the nurse's office. ULP-G stated she would need to delay administering R2's insulin for about 20 minutes until it warmed up first. ULP-G referenced R2's electronic medication administration record (EMAR). R2's provider's orders dated October 26, 2024, indicated Aspart insulin 100 u/ml, inject 1-7 units using sliding scale dosing (the number of units is based on the blood sugar level at that time), given subcutaneously (under the skin), twice daily (before breakfast and dinner) for diabetes. R2's EMAR dated February 2025, included step by step instructions for his Aspart insulin Flex pen	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 30 set up and administration and indicated after initial use, Flex Pen may be used for up to 28 days if it is kept at room temperature, below 86 degrees Fahrenheit (°F) or per manufacturer's guidelines. R4 R4's Service Plan dated January 30, 2025, included the service of medication administration. On February 3, 2025, at 3:20 p.m., the surveyor observed ULP-F set up and administer one oral medication and one eye drop. ULP-F administered Systane eye drops to both eyes. The eye drops lacked an open date. R4's signed prescriber's orders dated September 13, 2024, indicated Systane eye drops, one drop in each eye four times daily. R5 R5's Service Plan dated January 30, 2025, included the service of medication administration. On February 3, 2025, at 3:50 p.m., the surveyor observed ULP-F complete a blood sugar check and set up R5's Aspart insulin Flex Pen. The Flex Pen lacked an open date. Additionally, the surveyor noted R5's Lantus insulin Flex Pen in his section of the medication cart which also lacked an open date. R5's signed prescriber's orders dated October 24, 2024, indicated: -Aspart Flex Pen 100 u/ml, give 16-20 units three times daily per sliding scale dosing -Lantus Flex Pen 100 u/ml, give 32 units twice daily R5's EMAR also included step by step instruction	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 31 for the use of both Flex Pens and indicated Flex Pen may be used for up to 28 days if it is kept at room temperature, below 86 degrees Fahrenheit (°F) or per manufacturer's guidelines. On February 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to indicate an open date on the insulin Flex Pens once taken from the refrigerator and put into use. Aspart insulin manufacturer's instructions dated February 2015, indicated the Flex Pen may be used for up to 28 days when stored at room temperature, 86° F Lispro (Humulin) insulin manufacturer's instructions dated June 2022, indicated discard pen after 14 days when stored at room temperature. Lantus Solo-Pen manufacturer's instructions dated 2022, indicated the pen may be used for up to 28 days if stored at room temperature, below 86° F. Systane eye drops manufacturer's instructions dated September 14, 2024, indicated once opened, Systane eye drops are safe for 30 days. The licensee's Insulin Flex Pen policy dated April 1, 2024, indicated after initial use, Flex Pen may be used for up to 28 days if it is kept at room temperature 86° F, or per manufacturer's guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01950	Continued From page 32	01950		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R1) with the treatment of oxygen. 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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01950	Continued From page 33 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included congestive heart failure (CHF), hypertension, and type 2 diabetes. R1's Service Plan signed and dated February 5, 2025, (during time of the survey), lacked the treatments of oxygen and blood sugar checks. On February 4, 2025, at 7:45 a.m., the surveyor observed assisted living director in residency (ALDIR)-A changing R1's incontinence brief and repositioning R1 in her bed. The surveyor noted R1 in her bed with supplemental oxygen being provided via nasal canula and connected to an oxygen concentrator with a flow rate of 3 liters/minute (Lpm). On February 5, 2025, at 1:15 p.m., corporate director of nursing (CDON)-K and the surveyor observed R1's oxygen concentrator flow at 3 Lpm and was providing continuous oxygen to R1 via her nasal canula. R1's record lacked documentation for the treatment of oxygen. R1's signed prescriber's orders dated January 11, 2025, indicated oxygen via nasal canula at 1-2 liters/minute continuously. R1's Treatment Plan dated January 10, 2025, included the treatments of insulin administration, blood sugar checks, EZ stand (a mechanical lift system used for transfers), and oxygen. The Treatment Plan included instructions for the treatments of insulin and blood sugar checks;	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01950	Continued From page 34 however, the Treatment Plan lacked instructions for the treatment of oxygen. The licensee's RN did not provide direction regarding the administration of R1's oxygen therapy and did not provide the oxygen at the prescribed amount (1-2 liters/min). On February 5, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated she was not aware R1's oxygen was being administered at 3 Lpm and not at the ordered flow rate, and would follow up with this. Furthermore, CNS-B stated she missed adding R1's oxygen therapy to R1's Service Plan and Treatment Record and did not provide additional information/instruction for the ULP to reference while providing this treatment. The licensee's Treatment and Therapy Management policy dated April 1, 2024, indicated the licensee would provide documentation of specific resident instructions relating to the treatments or therapy administration, identify procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services, and any resident-specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01960	Continued From page 35 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented or provided as ordered for one of four residents (R1) receiving treatments. 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: R1's diagnoses included congestive heart failure (CHF), hypertension, and type 2 diabetes. R1's Service Plan signed and dated February 5, 2025, (during time of the survey), lacked the treatments of oxygen and blood sugar checks. On February 4, 2025, at 7:45 a.m., the surveyor observed assisted living director in residency	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01960	Continued From page 36 (ALDIR)-A changing R1's incontinence brief and repositioning R1 in her bed. The surveyor noted R1 in her bed with supplemental oxygen being provided via nasal canula and connected to an oxygen concentrator with a flow rate of 3 liters/minute (Lpm). On February 5, 2025, at 1:15 p.m., corporate director of nursing (CDON)-K and the surveyor observed R1's oxygen concentrator flow at 3 Lpm and was providing continuous oxygen to R1 via her nasal canula R1's signed prescriber's orders dated January 11, 2025, indicated oxygen via nasal canula at 1-2 Lpm continuously. R1's Treatment Plan dated January 10, 2025, included the treatments of insulin administration, blood sugar checks, EZ stand (a mechanical lift system used for transfers), and oxygen. The Treatment Plan included instructions for the treatments of insulin and blood sugar checks; however, the Treatment Plan lacked instructions for the treatment of oxygen. The licensee did not document the treatment of supplemental oxygen and did not provide the oxygen at the proper flow rate as ordered. On February 5, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated she was not aware R1's oxygen was being administered at 3 Lpm and not at the ordered flow, and would follow up with this. Furthermore, CNS-B stated she missed adding R1's oxygen therapy to R1's Service Plan and Medication/Treatment Administration record to allow the unlicensed personnel to document the administration of oxygen.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01960	Continued From page 37 The licensee's Treatment and Therapy Management policy dated April 1, 2024, indicated the licensee would provide documentation of specific resident instructions relating to the treatments or therapy administration, identify procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services, and any resident-specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *02/03/25*
Time: 11:30:00
Report: 1031251034

Food and Beverage Establishment Inspection Report

Location:
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights, MN55120
Dakota County, 19

Establishment Info:
ID #: 0038977
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517887010
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.

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

HOOD FILTERS HAVE DUST/DEBRIS ON FILTERS.

CLEAN HOOD FILTERS ON REGULAR BASIS TO PREVENT DUST/DEBRIS ACCUMULATION.

CORRECT ON SITE.

Comply By: 02/24/25

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.

HOOD SYSTEM NOT OPERATIONAL.

REPAIR HOOD SYSTEM SO IT CIRCULATES AIR WHENEVER COOKING EQUIPMENT IS TURNED ON.

CORRECT ON SITE.

Comply By: 02/17/25

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVES IN KITCHEN AND KITCHENTTE HAS SPLATTERS AND/OR FOOD DEBRIS.

CLEAN BOTH MICROWAVE INTERIORS.

CORRECT ON SITE.

Comply By: 02/07/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sani Bucket
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/Rice
Temperature: 162 Degrees Fahrenheit - Location: Tabletop Food Warmer
Violation Issued: No

Process/Item: Hot Hold/Shrimp Stir Fry
Temperature: 156 Degrees Fahrenheit - Location: Tabletop Food Warmer
Violation Issued: No

Process/Item: Cold Hold/Beef Strog
Temperature: 39 Degrees Fahrenheit - Location: 2-Door Cooler
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 39 Degrees Fahrenheit - Location: 1-Door Cooler
Violation Issued: No

Process/Item: Cold Hold/Apple Sauce
Temperature: 34 Degrees Fahrenheit - Location: Residential Refrigerator (same-day service)
Violation Issued: No

Type: Full
Date: *02/03/25*
Time: 11:30:00
Report: 1031251034
Mendota Heights White Pine

Food and Beverage Establishment Inspection Report

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

Nurse Evaluator on site: Deb Jacobson

All violations discussed with PIC during the inspection.

NOTES:

- Staff should check sanitizer concentration (150-400ppm Quat) on regular basis.

- Establishment does not have pasteurized eggs and does not prepare eggs. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

*ESTABLISHMENT HAS A KITCHENETTE AREA IN THE DINING ROOM THAT IS EQUIPPED WITH RESIDENTIAL EQUIPMENT (MICROWAVE, OVEN/STOVE, REFRIGERATOR), LAMINATE COUNTERS, WOODEN CABINETRY, WOODEN FLOORS, AND TEXTURED WALLS AND CEILING.

- Kitchenette 2-Comp sink has left basin designated for handwashing.

AREA IS USED ONLY FOR SAME-DAY SERVICE (4626.0506(G)(2)) OF ITEMS SUCH AS COOKIES DURING ACTIVITIES AND STORAGE OF MILK, JUICE, AND EMPLOYEE ITEMS. CEILING, WALLS, CABINETRY, AND COUNTERTOPS ARE FOUND TO BE IN GOOD CONDITION,

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *02/03/25*
Time: 11:30:00
Report: 1031251034
Mendota Heights White Pine

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 Environmental Health inspection report number 1031251034 of 02/03/25.

Certified Food Protection Manager: Regina R McDonald

Certification Number: FM116441 Expires: 03/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Regina Willis
Kitchen Manager

Signed: _____
Chris Foster
Public Health Sanitarian III
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us