Electronically Delivered

April 2, 2025

Licensee
Waverly Gardens
5919 Centerville Road
North Oaks, MN 55127

RE: Project Number(s) SL24195016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 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 . . ."

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:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 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
	24195	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY GARDENS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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: SL #24195016-0 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 87 residents, all of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 650 SS=F	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	0 650		

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0 650	Continued From page 1 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 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 the employee record contained the required content, including annual performance reviews for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-D). 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).	0 650		

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0 650	Continued From page 2 The findings include: RN-C and ULP-D were hired August 17, 2021, and August 19, 2022, respectively, and provided direct care services for residents. RN-C and ULP-D's employee records lacked documentation of an annual performance review. On February 25, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the annual performance reviews for RN-C and ULP-D were not done, and she was unsure sure why they were missed. The licensee's MN AL Delegation and Supervision policy, dated August 9, 2022, indicated the clinical administrator or RN designee was responsible for performance reviews and reviews would be conducted annually at a minimum. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and	0 775		

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0 775	Continued From page 3 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: During a facility tour on February 26, 2025, from 10:30 a.m. to 1:30 p.m., with environmental service director (ESD)-G, it was observed that hard-wired smoke alarms were over 10+ years old in the following rooms: Resident units-185, 197, 190, 171, 267, 266, 2002, 2011. Single- and multiple-station smoke alarms shall be replaced when: 1. They fail to respond to operability tests. 2. They exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. During a facility tour on February 26, 2025, at 11:30 a.m., ESD-G, verified the above listed observations while accompanying on the tour. ESD-G stated he understood the requirement and will begin a program to change out the alarms. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		

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0 780	Continued From page 4	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms throughout the facility. 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	0 780		

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0 780	Continued From page 5 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on February 26, 2025, from 10:30 a.m. to 1:30 p.m., with environmental service director (ESD)-G, it was observed that hard-wired smoke alarms did not interconnect with other smoke alarms in units 185, 197, and 190. Smoke alarms shall interconnect so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate. These deficient conditions were visually verified by ESD-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The 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	0 810		

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0 810	Continued From page 6 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. 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, provide required training. 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:	0 810		

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0 810	Continued From page 7 During a facility tour on February 26, 2025, from 10:30 a.m. to 1:30 p.m., with environmental service director (ESD)-G, the surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must be correctly labeled and accessible to staff, residents and visitors to reduce confusion and potential obstructions for egress in a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations. On February 26, 2025, ESD-G provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. Training: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, ESD-G stated they were using evacuation drills as training. No other training documentation was provided. On February 26, 2025, at 12:30 p.m., ESD-G stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 8 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-D). 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	01440		

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01440	Continued From page 9 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired August 19, 2022, to provide direct cares for the licensee's residents. On February 25, 2025, during continuous observations from 7:25 a.m. to 8:45 a.m., ULP-D was observed assisting the licensee's residents with morning cares and medication administration. ULP-D's record lacked documentation the RN conducted direct supervision within 30 days of performing delegated tasks. On February 25, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the 30-day supervision had not been completed for ULP-D. CNS-A further stated she was unsure why the supervision was missed. The licensee's MN AL Delegation and Supervision policy, dated August 9, 2022, indicated supervision of staff performing delegated tasks would be conducted by the RN within 30 calendar days of when the individual began working and first performed delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 10 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 date time sensitive medication for one of three residents (R3). 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: R3's service plan, dated February 10, 2025, indicated R3 received services including assistance with medication management and medication administration. On February 25, 2025, at 8:10 a.m., unlicensed personnel (ULP)-D obtained R3's locked medication box from the refrigerator. The surveyor observed R3's medications with ULP-D. The box contained two insulin pens: insulin aspart (a fast-acting insulin) and insulin glargine (a long-acting insulin). Both pens lacked a date to indicate when the pens were first opened. ULP-D stated she had not been putting dates on medications and could not remember if she had	01890		

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01890	Continued From page 11 been trained to do so. R3's medication administration record (MAR), dated February 2025, indicated on February 22, R3 started receiving 12 units of insulin aspart before breakfast, 7 units before lunch, and 6 units before dinner daily. The MAR further indicated R3 received 16 units of insulin glargine daily every morning. On February 25, 2025, at 4:00 p.m., clinical nurse supervisor (CNS)-A stated all insulin pens should be labled with the date they were opened and the unlicensed personnel should call the nurse if they have any questions. On February 26, 2025, at 9:45 a.m., licensed practical nurse (LPN)-F stated she was responsible for dating residents medications. LPN-F further stated if a medication came in on the weekend or a time when she was not working, it could get missed. LPN-F stated she was not sure if the unlicensed personnel were trained to date medications if the nurse was not available. The manufacturer's prescribing information for the use of novolog, insulin aspart injection, dated March 2023, indicated the medication should be discarded 28 days after first use. The manufacturer's prescribing information for the use of lantus, insulin glargine injection, revised June 2023, indicated the medication should be discarded 28 days after first use. The licensee's undated Medication Ordering and Receiving From Pharmacy document, , indicated when the original seal of an insulin pen was broken, the nurse would place a "date opened"	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24195	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY GARDENS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

(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 12 sticker on the medication and label it with the date is was opened. The licensee's AL RTask Nurse Review Expectations document, dated January 16, 2025, indicated the nurse would review insulin pens weekly, and verify the dates on the syringes. The document further indicated the nurse would check the residents' medication supply weekly and review for expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24195	A. BUILDING: _____ B. WING _____	02/26/2025

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WAVERLY GARDENS	5919 CENTERVILLE ROAD NORTH OAKS, MN 55127

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01910	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (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 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: R1 was admitted to the licensee on December 22, 2023, and discharged on September 4, 2024. R1's Discharge/Transfer Summary, indicated R1 received services including, assistance with medication management and medication administration. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, and quantity. On February 26, at 11:50 a.m., registered nurse (RN)-C stated she had not been documenting all the required information with the disposition of medications when a resident discharged, and she	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24195	A. BUILDING: _____ B. WING _____	02/26/2025

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01910	Continued From page 14 had not been aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the steps of the medication administration process were followed for one of three residents (R3). 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: R3's diagnoses included dementia.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24195	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 15 R3's service plan, dated February 10, 2025, indicated R3 received services including assistance with medication management and administration. R3's medication administration record (MAR), dated February 2025, indicated R3 received Miralax powder (for constipation), 17 grams (g) with 8 ounces of water on February 1, 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, and 25. On February 25, 2025, during continuous observation from 7:25 a.m., to 8:15 a.m., unlicensed personnel (ULP)-D assisted R3 with morning cares and dissolving 17 g of Miralax powder in eight ounces of water for medication administration. -at 8:15 a.m., ULP-D was observed escorting R3 to the dining room table, along with the glass of Miralax. ULP-D set the glass of Miralax down next to R3 who was seated across from R2 at the table. ULP-D left the dining room area and entered R4's apartment. On February 25, 2025, at 8:45 a.m., ULP-D stated they usually left the Miralax at the table with R3. ULP-D further stated it was easier to get R3 to drink the medication if it was set at the table with them, but she could understand why the medication should not be left unattended. On February 25, 2026, at 9:30 a.m., registered nurse (RN)-C stated staff were allowed to leave a glass of Miralax at the table with a resident in the secured dementia care unit, but they should be able to observe the resident and not leave the area. The licensee's AL Administration of Medication by Resident Assistants policy, revised February 28,	02320		

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02320	Continued From page 16 2023, indicated staff would observe the resident swallow their medications unless specifically instructed otherwise by the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *02/24/25*
Time: 13:28:27
Report: 8058251045

Food and Beverage Establishment Inspection Report

Location:
Waverly Gardens
5919 Centerville Road
North Oaks, MN55127
Ramsey County, 62

Establishment Info:
ID #: 0038755
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517654000
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Acid: = 700 at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SOUP
Temperature: 165 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: EGG SALAD
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 38 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: SOUP
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: TUNA
Temperature: 40 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 13:28:27
Report: 8058251045
Waverly Gardens

Food and Beverage Establishment Inspection Report

Process/Item: STRAWBERRY
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: BRISKET
Temperature: 36 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: TOMATO
Temperature: 36 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: TURKEY
Temperature: 39 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: SAUCE
Temperature: 137 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: RICE
Temperature: 154 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

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

HRD INSPECTOR - TAMMY CARLSON

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 8058251045 of 02/24/25.

Certified Food Protection Manager: JEFFERY VANDERSTEEN

Certification Number: 8119 Expires: 07/18/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
JEFFERY VANDERSTEEN
CHEF

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us