



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2025

Licensee

Willows & Waters Senior Living
707 Upper Meadow Lane Northwest
Rochester, MN 55901

RE: Project Number(s) SL30801016

Dear Licensee:

On June 2, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 6, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 6, 2025, found not corrected at the time of the June 2, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f)

The details of the violations noted at the time of this follow-up survey completed on June 2, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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>

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30801016-1 On June 2, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 6, 2025. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued: 1650.	{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.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 1 (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. This MN Requirement is not met as evidenced by:	{0 810}			
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}	Not reviewed during this survey		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 2 (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: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of three residents (R5) who received 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	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 3 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: R5 began to receive services from the licensee on June 16, 2021, with diagnoses to include dementia and bi-polar disorder. R5's Service Plan dated July 11, 2024, indicated she received assistance with bathing, dressing, grooming, medication administration/management, ostomy care (external bowel apparatus), and stand by assistance with transfers. The Service Plan lacked the service of oxygen/oxygen management. On June 2, 2025, at 1:30 p.m., the surveyor observed R5 in bed with oxygen via nasal cannula and an oxygen concentrator set with a continuous flow of 2 liters/minute. R5's medication administration record (MAR) dated May 2025, indicated "keep oxygen saturation levels greater than 90% with continuous oxygen use at 2 liters/minute at rest and 3 liters/minute with activity". The MAR also indicated weekly oxygen tubing changes and monthly nasal cannula changes. R5's signed physician's order dated May 1, 2025, indicated continuous oxygen at 2 liters/minute while at rest and 3 liters/minute during physical activity.	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 4 R5's treatment plan dated April 25, 2025, included the treatment of oxygen and ostomy care. R5's service plan lacked the service of oxygen/oxygen management to include a description of the service, the fees for the service, the frequency of the service, and the identification of staff or categories of staff who will provide the service as required. On June 2, 2025, at 1:40 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee "missed updating" R5's service plan to include the use/management of oxygen. The licensee's Service Plan policy dated August 1, 2022, indicated residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A Service Plan means the written plan between a resident or resident's designated representative and the facility about the services that will be provided to the reside, indicated a service plan will include: -a description of the services that are to be provided based on the most recent assessment and resident preferences -fees for services to be provided -the frequency of each service to be provided based on the most recent assessment and resident preferences -an identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) No further information was provided.	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/02/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 4, 2025

Licensee

Willows & Waters Senior Living L. L. C.
707 Upper Meadow Lane Northwest
Rochester, MN 55901

RE: Project Number(s) SL30801016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 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.

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:

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. 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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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: SL30801016-0 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility license. 1290: An immediate order was issued on March 4, 2025, at a level 3/Widespread (I) The licensee took action on March 4, 2025; however, the scope and level remain at I.	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.		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 1 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 one of one unlicensed personnel (ULP-C) during medication administration, blood sugar checks and toileting. 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: On March 3, 2025, at 11:10 a.m., the surveyor observed ULP-C don gloves while she set up R1's blood sugar equipment. ULP-C poked R1's fingertip for a drop of blood and used the blood	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 2 sugar monitor and test strip to obtain a blood sugar reading. She then referenced the medication book to determine how much insulin was needed (based on R1's blood sugar level), picked up R1's insulin pen, dialed it to the proper dose, attached a new needle, primed the pen/needle with two units of insulin and handed the insulin pen to R1 who self-administered the insulin. ULP-C then picked up a pen and documented R1's blood sugar reading and the amount of insulin R1 received. ULP-C then removed her gloves. ULP-C used the same set of gloves throughout the entire process and touched several surfaces after she obtained the drop of blood for R1's blood sugar check. On March 3, 2025, at 11:20 a.m., ULP-C donned a clean set of gloves and set up R2's medications from her medication container. ULP-C went to R2's room administered her oral medications and used R2's blood sugar sensor/monitor to obtain a blood sugar reading. ULP-C then prepared R2's insulin pen, by attaching a new needle, primed the needle with two units of insulin and handed the insulin pen to R2 who self-administered the insulin. ULP-C gathered the equipment and returned to the medication room, documented R2's blood sugar reading and the medications administered, and then removed her gloves. ULP-C obtained a new set of gloves (without sanitizing her hands) and moved on to the next resident for medication set up. On March 3, 2025, at 11:30 a.m., ULP-C gathered R3's supplies for a blood sugar check and insulin pen administration and went to R3's room. ULP-C scanned R3's blood sugar sensor to obtain a reading, referenced R3's insulin sliding scale and prepared her insulin pen by attaching a new needle, priming the pen with two units of	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 3 insulin and handed the insulin pen to R3 who self-administered the insulin. ULP-C gathered supplies and returned to the medication room, documented results and insulin administration and then removed her gloves. ULP-C kept the same set of gloves on during the entire process of set up, touching multiple surfaces/doorknobs, and returning to the medication room for documentation. On March 3, 2025, at 11:37 a.m., ULP-C donned new gloves, gathered R4's blood sugar equipment and insulin pen equipment. She went to R4's room with the equipment, prepped R4's finger for a finger poke, obtained a drop of blood and placed the drop on a blood sugar test strip. With the same gloves, ULP-C picked up R4's insulin pen, determined it was not the proper insulin pen, picked up the proper (aspart) insulin pen, attached the needle, and primed with two units of insulin, and administered the insulin to R4's lower abdomen. ULP-C then assisted R4 to the bathroom to empty his suprapubic (catheter that enters the abdomen to the bladder) catheter bag. ULP-C drained the urine contents into the toilet, wiped the catheter bag port, replaced it into the appropriate bag sleeve and placed the bag into a cloth bag (for privacy). ULP-C then escorted R4 back to his room and removed her gloves. ULP-C gathered the blood sugar and insulin equipment and returned to the medication room and documented R4's insulin administration and blood sugar results. ULP-C failed to change her gloves and sanitize her hands following obtaining the blood sugar results, giving insulin, emptying the catheter bag and touching multiple surfaces. On March 3, 2025, at 2:25 p.m., ULP-C donned new gloves and obtained R5's oral medications	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 from the medication room. ULP-C went to R5's room assisted R5 with a transfer to her walker and administered her oral medications. ULP-C then assisted R5 to the bathroom and assisted her with removing pants and sitting on the toilet. ULP-C then emptied the contents of R5's colostomy bag into a container, rinsed the colostomy bag, instilled deodorant drops into the colostomy bag and fastened the bag clamp. ULP-C continued with the same gloves and used a wet wipe to cleanse R5's peri-area and removed her wet incontinence brief. ULP-C assisted R5 with a clean brief and pulled R5's pants up. ULP-C grabbed R5's walker and assisted her to a standing position and to the sink where R5 washed her hands. ULP-C then removed her gloves and threw them away. ULP-C escorted R5 back to her room and returned to the medication room where she documented her tasks. ULP-C failed to change her gloves and sanitize her hands throughout the process of toileting R5, working with bowel contents, skin care and donning a clean brief and clothing, and touching other surfaces. On March 4, 2025, at 11:45 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she expected all staff to change gloves and sanitize hands between performing procedures such as blood sugar checks, managing colostomy bags, and between resident contact. The licensee's Hand washing policy dated August 1, 2021, indicated proper hand washing techniques should be used to protect the spread of infection hand washing shall be completed after changing diapers or cleaning up after someone who has used the toilet. When conducting a procedure requiring the use of	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 580	Continued From page 6 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: On March 3, 2025, at 1:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee did not have anything formally written as a quality improvement plan, and they "did things" but were not writing things down nor giving credit for the things they've done. The licensee's Quality Management Project policy dated August 1, 2021, indicated [facility name] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The policy further indicated: 1. Identified staff shall, using data collected from logged resident complaints, outcomes from MDH surveys or investigations, outcomes from resident satisfaction surveys, or other sources of data, select at least one area to focus on in the form of a quality improvement initiative. 2. Data should be collected on the target area to develop a baseline. Using a performance improvement methodology, such as Plan-Do-Check-Act (PDCA), a Performance Improvement Team shall be organized to enact the PDCA cycle.	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 580	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 630	Continued From page 8 The findings include: R2 R2 was admitted to the facility under the licensee's Assisted Living Facility (ALF) license on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-a chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received services to include assistance with dressing, toileting, bathing, medication management, continuous positive airway pressure (CPAP-device used for sleep apnea), blood sugar monitoring, and insulin injections. On March 3, 2025, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-C set up and administer oral medications, check a blood sugar, and administer insulin to R2. R2's IAPPs dated December 11, 2024, and March 3, 2025, included the statement, "Is the resident susceptible to abuse by another individual including other vulnerable adults." A box next to that statement was marked "false". The section also included an intervention statement to read, "Staff to monitor for signs and symptoms of abuse/neglect from others and report to nursing promptly." R4 R4 was admitted to the facility under the licensee's ALF license on November 6, 2024, with diagnoses including type two diabetes, intellectual disability, obstructive sleep apnea with CPAP use,	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 630	Continued From page 9 anxiety, recurrent urinary tract infection with presence of a suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received assistance with dressing, grooming, toileting and transfers, medication management, suprapubic catheter maintenance, CPAP management, blood sugar monitoring and insulin administration. On March 3, 2024, at 11:35 a.m., the surveyor observed ULP-C check R4's blood sugar, administer insulin, and assist with emptying R4's suprapubic catheter. R4's IAPP dated November 20, 2024, indicated R4 was unable to report abuse and neglect, and was unable to independently manage finances, with a Power of Attorney managing finances. Furthermore, R4's IAPP included the statement, "Is the resident susceptible to abuse by another individual including other vulnerable adults." A box next to that statement was marked "false". The section also included an intervention statement to read, "Staff to monitor for signs and symptoms of abuse/neglect from others and report to nursing promptly." R2 and R4's IAPP did not accurately depict their susceptibility to abuse by others including other vulnerable adults. On March 4, 2025, at 11:57 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all the licensee's residents are considered vulnerable adults and were vulnerable to abuse by others. She further stated the IAPP form being used could be confusing for	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 630	Continued From page 10 how the nurse reads it, but it should indicate the residents are vulnerable adults and vulnerable to abuse. The licensee's Individual Abuse Prevention Plan dated August 1, 2021, [licensee's name] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. 1) The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults 2) The plan shall contain the resident's risk of abusing other vulnerable adults 3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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 records must include the following information: (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;	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 650	Continued From page 11 (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 observation, interview, and record review, the licensee failed to ensure employee records included evidence of training/competency content for Purewick external catheter for one of one unlicensed personnel (ULP-C). 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: ULP-C was hired on June 19, 2023, to provide direct care services to residents of the facility. On March 3, 2025, at 11:25 a.m., the surveyor observed ULP-C assist R2 with checking her blood sugar, medication, and insulin administration. The surveyor noted a Purewick	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 650	Continued From page 12 machine on the floor next to R2's bed. The machine was not in use at the time. ULP-C stated it was used during the night and staff assisted R2 with placement of the external catheter and management of the machine. ULP-C stated she and other staff had been trained by the licensee's registered nurse (RN). ULP-C's employee file included several training and competency documents; however, ULP-C's employee file lacked evidence of training and competency had been completed for ULP-C by the licensee's RN. On March 4, 2025, at 4:50 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated all staff had a group training/competency with the Purewick equipment for the licensee's two residents who used this equipment; however, no paperwork was created or signed by the licensee's RN. The licensee's Employee Record policy dated August 1, 2021, indicated the licensee would maintain records of all training and in-service education required and/or provided including record of competency testing as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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	
0 660	Continued From page 13 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-D). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 660	Continued From page 14 ULP-D ULP-D's employee record indicated a hire date of July 9, 2024, to provide direct care services to the licensee's residents. On March 4, 2025, at 8:35 a.m., ULP-D assisted R4 with medication administration, a blood sugar check, and insulin injection. ULP-D's employee file lacked documentation of a completed health history and symptom screening, and evidence she completed TST skin test or blood test to confirm she was free of TB. On March 5, 2025, at 2:05 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-D had not completed a TB screening nor TB testing since her hire date. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated [facility name] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC),	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 660	Continued From page 15 Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The program includes a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The policy further indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 16 (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 program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 6, 2025, at 10:00 a.m., the surveyor reviewed the contents of the licensee's Emergency Preparedness (EP) plan. The plan was last reviewed/updated on June 1, 2024. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z:	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 17 - evidence the licensee completed staff/resident training on the facility's EP plan on an annual basis as required. - evidence the licensee conducted 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 - evidence the licensee reviewed their Missing Resident plan on a quarterly basis On March 6, 2025, at 11:15 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she had not conducted any exercises/drills with the EP plan, and stated she encouraged the staff to review the EP binder to review the contents of the plan; however, did not have evidence the staff had done so. LALD/LPN-A further stated she "forgot about the requirement to review the Missing Resident plan" on a quarterly basis. The licensee's Emergency Preparedness plan policy dated October 20, 2022, indicated: Training -All staff will receive initial training on our emergency preparedness plan, as well as annual refresher training. Exercises and Drills - [licensee 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 18 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in two of two resident's records (R2, R4) were authenticated by signature and title of the person making the entry. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents). The findings include:	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
0 690	Continued From page 19 R2 R2's record included Resident Cares dated February 1, 2025, through February 28, 2025, included multiple daily tasks and several staff initials; however, the record lacked staff signatures with credentials/titles. R2's Progress notes with entries dating from May 15, 2024, through February 5, 2025, were initialed by licensed assisted living director/licensed practical nurse (LALD/LPN)-A; however, the record lacked staff signatures with credentials/titles. R4 R4's record included Resident Cares dated February 1, 2025, through February 28, 2025, included multiple daily tasks and several staff initials; however, the record lacked staff signatures with credentials/titles. R4's Progress notes with entries dating from November 6, 2024, through January 16, 2025, were initialed by LALD/LPN-A; however, the record lacked staff signature with credentials/titles. On March 4, 2025, at 4:30 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated, "We had signature pages for each of the resident's task records in their books; however, they were at the kitchen table and were spilled on, became unreadable, and I have not replaced them." LALD/LPN-A indicated all resident signature pages were impacted and unreadable. The licensee's undated, Resident Record-documentation policy indicated the staff authorized to document in a resident record will	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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
0 690	Continued From page 20 do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 21 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. 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 March 4, 2025, at 9:58 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 22 The licensees FSEP titled 9.06 Fire Policy, dated 10/20/2022, lacked the following required content: The FSEP included standard employee procedures but lacked specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan contained language such as smoke compartment doors and fire doors. The plan had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems stated in the plan. The plan lacked procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but lacked specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 23 and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. LALD/LPN-A stated they provide annual training provided by a third party but do not provide in-person training specific to the facility FSEP. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees every other month. LALD/LPN-A stated they conduct fire drills every quarter throughout the year. LALD/LPN-A provided documentation indicating drills had been conducted in January, April and September 2024. LALD/LPN-A stated these were the only drills conducted in 2024. During an interview on March 4, 2025, at 10:35 a.m., LALD/LPN-A stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01060	Continued From page 24 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R3).	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01060	Continued From page 25 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: R3 was admitted to assisted living services on September 3, 2024. R3's Service Plan dated September 3, 2024, indicated she received services to include, assistance with bathing, medication management, blood sugar monitoring, and insulin administration. R3's progress notes included: -February 14, 2025, R3 was admitted to [hospital name] for further care and testing -February 19, 2025, R3 returned to [facility name], medication administration record (MAR) updated R3's After Visit Summary dated February 19, 2025, indicated a hospitalization from February 14, 2025, through February 19, 2025, for abnormal liver function tests. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01060	Continued From page 26 Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On March 3, 2025, at 3:25 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated, "I feel like I had a form that I knew about but have forgotten to use it. I recall the need to let the ombudsman know about being in the hospital and not returning within four days." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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
01290	Continued From page 27 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for one of 11 employees (clinical nurse supervisor (CNS)-B). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on March 4, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's employee roster printed on March 3, 2025, indicated CNS-B was hired on January 7, 2024, to provide nursing and direct care services for the licensee's residents.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01290	Continued From page 28 On March 4, 2025, at 9:15 a.m., the licensee provided the surveyor with the licensee's NETStudy roster dated March 3, 2025. CNS-B was not noted on the licensee's NETStudy roster. CNS-B's record included a registered nurse (RN) license issued by the Minnesota Board of Nursing effective June 19, 2003, with an expiration date of March 31, 2027. On March 4, 2025, at 11:20 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated CNS-B did not complete a background study when CNS-B was hired and thought since CNS-B held a professional license, she was exempt from a required background study/fingerprinting process. LALD/LPN-A stated she was not aware the exemption only applied to health board licenses issued after 2018. LALD/LPN-A further stated CNS-B had worked independently and without direct supervision since her hire date. The licensee failed to ensure CNS-B had a current and eligible background study. The licensee's Background Study policy dated August 1, 2021, indicated [licensee name] will conduct a Minnesota Department of Human Services background study on all employees, volunteers, and contractors. No employee may provide direct services or have direct contact with residents until an acceptable background study result has been received. Minnesota Department of Health (MDH) frequently asked questions (FAQ) page indicated "Individuals who were licensed by an HLB (health licensing board) prior to implementation of	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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
01290	Continued From page 29 214.075 background checks in 2018, must stay on the entity's NETStudy 2.0 roster. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on March 4, 2025; however, the scope and level remain at I.	01290			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01530	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C, ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under the Assisted Living license. ULP-C ULP-C had a hire date of June 19, 2023, and provided direct care services under the licensee's Assisted Living license. On March 3, 2025, at 2:05 p.m., the surveyor observed ULP-C administer oral medications and an inhaler to R7. ULP-C's employee record included various training records and competencies; however, her training lacked evidence of any dementia training with the required content was assigned or completed. ULP-D	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01530	Continued From page 31 ULP-D had a hire date of July 9, 2024, and provided direct care services under the licensee's Assisted Living license. On March 4, 2025, at 8:20 a.m., the surveyor observed ULP-D administer medications, check a blood sugar, and administer insulin to R4. ULP-D's employee record included various training and competency documents; however, her record lacked evidence dementia training with the required training topics had been assigned or completed. The licensee failed to ensure ULP-C and ULP-D received the required eight hours and training topics of dementia training within 160 hours of time worked. Additionally, ULP-D lacked the required two hours of dementia training annually. On March 6, 2025, at 2:05 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated neither ULP-C or ULP-D had dementia training assigned to them, and neither had met the required training hours and both had worked more than 160 hours. LALD/LPN-A further stated she was not aware of how much dementia training the other employees had completed in the past couple years. The licensee's Dementia Training policy dated August 1, 2021, indicated all [licensee's name] staff are required to complete dementia training at the time of hire and annually thereafter. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. All staff will complete two (2) hours of additional training for each 12 months of work thereafter. Required dementia training topics include:	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01530	Continued From page 32 - An explanation of Alzheimer's disease and other dementias - Assistance with activities of daily living - Problem solving with challenging behaviors - Communication skills - Person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
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	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 33 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: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R2) who received 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: R2 was admitted to the facility under the licensee's Assisted Living Facility (ALF) license on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received assistance with dressing, toileting, bathing, medication management, continuous positive airway pressure (CPAP-used for sleep apnea), blood sugar monitoring, and insulin injections. On March 3, 2025, at 11:20 a.m., the surveyor	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 34 observed unlicensed personnel (ULP)-C set up and administer oral medications, check a blood sugar, and administer insulin to R2. The surveyor noted a Purewick machine on the floor next to R2's bed. The machine was not in use at the time. ULP-C stated it was used during the night and staff assisted R2 with placement of the external catheter and management of the machine. R2's comprehensive assessment dated March 3, 2025, included the use of a Purewick system to assist with urinary incontinence during the night. R2's signed physician's order dated August 27, 2024, indicated use of Purewick system to be used nightly for urinary incontinence. R2's service plan lacked the service of Purewick incontinence system to include a description of the service, the fees for service, and the frequency of the service, and the identification of staff or categories of staff who will provide the service as required. On March 4, 2025, at 1:56 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated R2 had a physician's order for the Purewick system, and staff assisted her with placement and maintenance of the equipment; however, the licensee failed to ensure R2's Service Plan included the service of the Purewick system. The licensee's Service Plan policy dated August 2, 2021, indicated residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 35 resident's needs and preferences. A Service Plan means the written plan between a resident or resident's designated representative and the facility about the services that will be provided to the reside, indicated a service plan will include: -a description of the services that are to be provided based on the most recent assessment and resident preferences -fees for services to be provided -the frequency of each service to be provided based on the most recent assessment and resident preferences -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. This MN Requirement is not met as evidenced	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 36 by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. 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: R1 R1 was admitted to the facility on February 1, 2019, with diagnoses to include type 2 diabetes, anxiety and depression. R1's Service Plan dated July 11, 2024, included medication and insulin administration. R1's signed physician orders dated January 27, 2025, included: -Insulin Aspart Flex pen 100 units/milliliter (u/ml), inject base 26 units with sliding scale under the skin at breakfast, 22 units with sliding scale at lunch, 26 units with sliding scale at supper; and -Lantus Solostar 100 units/ml, inject 54 units under the skin every night On March 3, 2025, at 11:10 a.m., the surveyor observed unlicensed personnel (ULP)-C complete R1's blood sugar check and prepare	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 37 R1's Aspart insulin pen for administration. ULP-C picked up R1's insulin pen from the medication cart drawer, selected a new needle and attached it to the insulin pen (without wiping the insulin pen rubber tip), dialed the insulin to 2 units to prime the needle, and dialed the insulin pen to the designated dose (24 units). ULP-C then handed the insulin pen to R1 who then self-administered into her lower abdomen. ULP-C documented R1's blood sugar reading and insulin dose as dialed and administered in R1's Medication Administration Record (MAR). R2 R2 was admitted to the facility on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-a chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received medication management. R2's signed physician orders dated February 3, 2025, indicated: -Lantus Solostar 100 units/ml, give 45 units daily -Novolog flex pen 100 units/ml, give 10 units with midday meal and 4 units every evening On March 3, 2025, at 11:20 a.m., the surveyor observed ULP-C set up and administer oral medications, check a blood sugar, and prepare R2's Novolin insulin pen for administration. ULP-C referenced R2's medication administration record (MAR), picked up R2's Novolin pen, selected a new needle, and attached the new needle to the insulin pen (without wiping the insulin pen rubber tip), dialed the insulin pen to 2 units to prime the needle, and dialed to the	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 38 designated 10 units of insulin. R2 self-injected the insulin to her lower abdomen. ULP-C then returned to the medication room and documented R2's medication administration, blood sugar reading and insulin dose administered. R3 R3 was admitted to the facility on September 3, 2024, with diagnoses to include type 2 diabetes. R3's Service Plan dated September 3, 2024, indicated she received medication management and insulin injections. R3's signed physicians orders dated February 21, 2025, indicated: Novolin 100 units/ml, give 15 units in the morning and 15 units in the evening; Novolog flex pen 100 units/ml, inject 0-13 units under the skin three times daily before meals in a sliding scale; maximum 40 units/day R3's sliding scale order indicated for blood sugars: give Novolog insulin: 140-179, 4 units 180-219, 6 units 220-259, 8 units 260-299, 10 units 300-339, 12 units 340-379, 13 units 380-399, 14 units over 400, call provider On March 3, 2025, at 11:30 a.m., ULP-C prepared R3's blood sugar monitoring equipment and Aspart (Novolog) insulin pen for insulin administration. ULP-C assisted R3 by scanning R3's electronic blood sugar monitoring device over the sensor (provides continuous blood level	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 39 readings), and prepared R3's insulin pen for administration. ULP-C attached a new needle to the pen (without wiping pen tip), primed the pen with 2 units of insulin and dialed the pen to the desired dose. ULP-C handed the insulin pen to R3 who self-administered the insulin in her lower abdomen. ULP-C gathered her equipment and returned to the medication room and documented R3's blood sugar and insulin dose administered. R4 R4 was admitted to the facility on November 6, 2024, with diagnoses including type two diabetes, intellectual disability, obstructive sleep apnea with CPAP (continuous airway positive pressure) use, anxiety, recurrent urinary tract infection with presence of suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received medication management. R4's signed physician orders dated December 11, 2024, included: -Aspart (Novolog) insulin 100 units/ml, inject under the skin - 14 units in the morning, 7 units with lunch, and 10 units with dinner; -Novolin 100 units/ml inject 45 units under the skin at 7:00 a.m. daily On March 3, 2024, at 11:35 a.m., the surveyor observed ULP-C prepare blood sugar monitoring equipment and set up R4's Novolog insulin pen. ULP-C checked R4's MAR, took R4's Novolog insulin pen from the medication cart. The surveyor noted the insulin pen was missing its protective cap, exposing the rubber tip of the	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 40 insulin pen. ULP-C obtained a new needle and attached the needle to the insulin pen (without wiping the pen tip with an alcohol wipe), primed the needle with 2 units of insulin, and dialed the pen to the designated dose of 7 units. ULP-C went to R4's room, completed a blood sugar check, wiped an area of R4's right lower abdomen and administered the Novolog insulin. Following the completion of other tasks with R4, ULP-C returned to the medication room, returned supplies from R4's blood sugar and insulin administration, and documented the insulin given and the blood sugar results in R4's MAR. On March 4, 2025, at 8:38 a.m., the surveyor observed ULP-D set up oral, nasal, and nebulized medications, and prepared R4's Novolin insulin pen. The Novolin insulin (long-acting insulin) pen was missing its protective cap, exposing the rubber tip of the insulin pen. ULP-D obtained a new needle and attached the needle to the insulin pen (without wiping the pen tip with an alcohol wipe), dialed the insulin pen to 2 units to prime the needle and then dialed to 45 units as indicated by R4's MAR. ULP-D also prepared R4's Novolog (short acting insulin) pen, by picking the insulin pen up, and compared the label to the MAR. The Novolog insulin pen was also missing its protective cap, ULP-D attached a new needle (without wiping the insulin pen's rubber tip), primed the pen with 2 units of insulin, and then dialed to 14 units. ULP-D wiped the skin on R4's lower left abdomen with an alcohol wipe and administered the 14 units of Novolog insulin. ULP-D went on to R4's Novolin insulin (rolled it gently to mix the insulin), wiped the skin on R4's lower right abdomen and injected the Novolin 45 units. ULP-C and ULP-D failed to follow the proper	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 41 procedure to wipe the pen tip with an alcohol wipe prior to placing a new needle to the pen. On March 4, 2025, at 11:45 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she knew a couple of the residents had insulin pens with missing caps and expected the ULP to follow the procedure to wipe the pen tip with an alcohol wipe prior to placing a new needle to the pen. The licensee's Insulin Administration policy/procedure dated August 1, 2021, indicated "Roll the insulin pen between your hands to gently mix the insulin. Clean the rubber stopper with an alcohol swab and twist on new needle." Novolog manufacturer's instructions dated February 2023, indicated for the user to remove the flex pen cap and wipe the flex pen tip with an alcohol wipe prior to placing a new needle on the flex pen tip. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 42 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 document the reason why medication administration was not completed as prescribed for one of six residents (R4). Furthermore, the licensee failed to include staff signatures and titles with four of four residents (R1, R2, R3, R4) medication administration records. 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: DOCUMENTATION OF MEDICATIONS NOT GIVEN R4 On March 4, 2025, at 8:38 a.m., the surveyor observed ULP-D set up R4's medications. ULP-D obtained R4's medication minder (weekly pill box), counted 10 pills and compared to what the nurse had set up and documented. ULP-D took out R4's bottle of polyethylene glycol (for	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 43 constipation), measured 17 grams into a plastic cup, and checked R4's MAR for his other 8:00 a.m. medications. ULP-D stated R4 sometimes refused some of his medications and she knew R4's hydrocortisone, diclofenac, and lidocaine patch were out of stock and being reordered. ULP-D took R4's blood sugar testing equipment, his oral medications as set by the nurse, Novolin and Novolog insulin pens, fluticasone nasal spray, polyethylene glycol powder, and budesonide nebulizer to R4's room and administered them. R4's MAR dated March 2025, included instructions for ULP that read: A. Put initials in appropriate box when medication (med) is given B. Circle initials when not given C. State reason for refusal/omission on back of form D. PRN (as needed meds): Reason given, and result must be noted on back of form R4's MAR dated March 2025, included circles around the following medications/dates/times: -polyethylene glycol 17 grams (gm) 1 packet orally twice daily for constipation-staff initials circled for 7:00 a.m. on March 2, 3, 2025, and 4:30 p.m. on March 2, 2025; -fluticasone 50 micrograms (mcg) nasal spray, give two sprays in each nostril daily for rhinitis (inflammation of the nasal/sinus tissues)- staff initials circled for 8:00 a.m. on March 1, 2, and 3, 2025; -tiotropium Bromide Monohydrate 2.5 mcg inhaled two puffs daily for asthma- staff initials circled for 8:00 a.m. on March 1, 2, 2025; -lidocaine 5% pain patch, apply one patch topically daily for pain (refuses often)- staff initials circled for putting patch on at 7:00 a.m. on March	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 44 1, 2, 3, 2025, and taking patch off at 8:00 p.m.; -diclofenac sodium 1% gel, apply 4 grams daily for mild pain-staff initials circled for 4:00 p.m. and 8:00 p.m. for March 1, 2, 3, 2025; and -nystatin 100,000 units, apply topically twice daily for rash, no staff initials documented for 8:00 a.m. on March 3, 2025, and 8:00 p.m. on March 1, 2, 2025. R4's MAR included multiple entries with circles; however, the licensee failed to indicate why the "circled" medications were not administered or failed to document anything (initials or medications not available or medication was refused by R4). Furthermore, ULP-D circled R4's fluticasone nasal spray for March 3, 2025, at 8:00 a.m.; however, ULP-D was observed to administer the nasal spray. On March 5, 2025, at 2:30 p.m., LALD/LPN-A stated, "We do not document further when the staff circle their initials, the previous registered nurse (RN) felt it to be too complex for staff, however, I can see just circling the initials doesn't tell why it's circled; was the medication refused or not available." STAFF AUTHENTICATION WITH TITLE FOR MEDICATIONS ADMINISTERED R1 R1 was admitted on February 1, 2019, with diagnoses to include type 2 diabetes, anxiety and depression. R1's Service Plan dated July 11, 2024, included medication and insulin administration. R1's MAR dated February 2025, and March 2025,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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 45 included staff initials for medications administered; however, R1's record lacked the signature and title of the person who administered the medication. R2 R2 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-a chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received medication management. R2'S MAR dated February 2025, and March 2025, included staff initials for medications administered; however, R2's record lacked the signature and title of the person who administered the medication. R3 R3 was admitted to the facility on September 3, 2024, with diagnoses including type 2 diabetes. R3's Service Plan dated September 3, 2024, indicated she received medication management and insulin injections. R3'S MAR dated February 2025, and March 2025, included staff initials for medications administered; however, R3's record lacked the signature and title of the person who administered the medication. R4	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 46 R4 was admitted on November 6, 2024, with diagnoses including type two diabetes, intellectual disability, obstructive sleep apnea with CPAP (continuous airway positive pressure) use, anxiety, recurrent urinary tract infection with presence of suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received services to include medication management. R4'S MAR dated February 2025, and March 2025, included staff initials for medications administered; however, R4's record lacked the signature and title of the person who administered the medication. On March 5, 2025, at 2:35 p.m. LALD/LPN-A stated the licensee had signature pages with signatures and staff titles in the resident's binders; however, they have been spilled on and found to be unreadable and since removed. The licensee's Medication Management-Administration and Setup policy dated August 1, 2021, indicated the nursing staff and unlicensed personnel trained to provide medication administration at [licensee name] will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided. Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. For medication reminders or administration, the documentation must include the medication name, dosage, date and time administered, and	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 47 method and route of administration. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals. ULP will also document any 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. If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for two of four residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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
01820	Continued From page 48 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: R2 R2 was admitted on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received services to include medication management. On March 3, 2025, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-C set up and administer oral medications, check a blood sugar, and administer insulin to R2. R2's signed physician orders dated February 3, 2025, indicated: -Lantus Solostar 100 units/ml, give 45 units daily under the skin (insulin for diabetes) -Novolog flex pen 100 units/ml, give 10 units with midday meal and 4 units every evening (insulin for diabetes) -albuterol 108 micrograms/actuation (mcg/ACT) inhaler, inhale one to two puffs my mouth every four to six hours as needed for wheezing or shortness of breath; -aspirin 325 milligrams (mg), take one tablet by mouth daily for heart health;	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01820	Continued From page 49 -cholecalciferol 50 mcg, take one capsule by mouth daily (supplement) -fluticasone 50 mcg/ACT nasal spray, use two sprays in each nostril daily (nasal congestion) -furosemide 20 mg, take one tablet by mouth daily as needed for leg swelling; glucose 4 grams (gm), chew four tablets if needed for low blood sugar; -levothyroxine 112 mcg, take one tablet by mouth one time daily (thyroid) -lisinopril 10 mg, take one tablet by mouth one time daily in the morning (blood pressure); -Metformin 500 mg, take two tablets by mouth two times daily (blood sugar control); -Montelukast 10 mg, take one tablet by mouth one time daily (allergies) -pravastatin 80 mg, take one tablet by mouth one time daily (cholesterol); -simethicone 80 mg, chew one tablet every six hours as needed for flatulence (gas); -tiotropium 18 mcg/ACT capsule, place one capsule into inhaler and inhale one time daily (asthma); and -Tramadol 50 mg, take one tablet by mouth two times daily (pain) R2's medication administration record (MAR) dated March 2025, also included the following: -Novolog insulin, inject 6 units under the skin, with assigned time at 4:30 p.m. -acetaminophen 500 mg, give two tablets by mouth two times daily for mild pain. do not exceed 4000 mg/24 hours, (scheduled doses) -acetaminophen 500 mg, give two tablets by mouth every six hours as needed for mild pain or fever, do not exceed 4000 mg/24 hours -Albuterol 90 mcg inhaler, give one to two puffs orally every four to six hours as needed for shortness of breath or cough -Albuterol 90 mcg inhaler, inhale two puffs daily	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01820	Continued From page 50 (scheduled for shortness of breath) R2's record lacked signed physician orders for: - Novolog 6 units given at 4:30 p.m.; -scheduled Albuterol 90 mcg inhaler; and -scheduled acetaminophen 500 mg, two tablets given by mouth twice daily On March 5, 2025, at 2:10 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she could not find the signed order for R2's Novolog 6 units at 4:30 p.m., nor for the scheduled Albuterol. LALD/LPN-A further stated she had not asked for an order for R2's scheduled Tylenol, stating, "I wasn't certain we were required to obtain an order if we already had one for it as a PRN." R4 R4 was admitted on November 6, 2024, with diagnoses including type two diabetes, intellectual disability, obstructive sleep apnea with CPAP (continuous airway positive pressure) use, anxiety, recurrent urinary tract infection with presence of suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received medication management. On March 3, 2024, at 11:35 a.m., the surveyor observed ULP-C check R4's blood sugar, administer insulin, and assist with emptying R4's suprapubic catheter. R4's signed physician orders dated December 4, 2024, and December 11, 2024, indicated: -tiotropium Bromide 2.5 micrograms aerosol, inhale two puffs daily;	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01820	Continued From page 51 -acetaminophen 500 mg, give two tablets by mouth every six hours as needed for pain; -albuterol sulfate 108 mcg, inhale two puffs by mouth every four hours as needed for wheezing or shortness of breath -apixaban 5 mg, give one tablet by mouth two times daily (blood thinner) -bisacodyl suppository, 10 mg, insert one suppository rectally one time daily as needed for constipation -carbamide Peroxide 6.5% administer 10 drops into each ear two times daily for three days, irrigate ears on the fourth day, do monthly (clear ear canal) -clonazepam 0.5 mg, give one tablet by mouth every night for anxiety/sleep -diclofenac sodium 1% gel, apply 4 gms topically four times daily (for pain) -fluticasone propionate 50 mcg, administer 2 sprays into each nostril one time daily if needed for rhinitis (inflammation of nasal/sinus passages) -hydrochlorothiazide 25 mg give one tablet by mouth one time daily (blood pressure) -ipratropium-albuterol 0.5-2.5 mg, nebulize 3 ml four times daily as needed for wheezing -lidocaine patch 5%, apply to skin two times daily for pain -loperamide 2 mg, give one capsule by mouth four times daily as needed for diarrhea, loratadine 10 mg, give one tablet daily for allergies -melatonin 3 mg, give two tablets by mouth every night (sleep) -metoprolol tartrate 50 mg, give one tablet by mouth two times daily (heart rate control) -Montelukast 10 give one tablet by mouth every night (allergies) -Nystatin powder 100,000 units/gm, apply topically two times daily (antifungal) -omeprazole 20 mg, give one capsule by mouth one time daily (antiulcer)	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01820	Continued From page 52 -polyethylene glycol 17 gm/scoop, take 17 gms two times daily (constipation) -sertraline 25 mg, give one tablet by mouth one time daily -tamsulosin 0.4 mg, give two capsules by mouth one time daily, -budesonide 0.5 mg/2 ml, by nebulization two times daily -Aspart (Novolog) insulin 100 units/ml, inject under the skin- 14 units in the morning, 7 units with lunch, and 10 units with dinner; -Novolin 100 units/ml inject 45 units under the skin at 7:00 a.m. daily R4's MAR dated March 2025, included the signed orders listed above; however, the MAR also included: -aspirin 81 mg, give 1 tablet orally daily for propholaxix [sic] R4's record lacked signed prescriber's orders for aspirin On March 5, 2025, at 3:20 p.m., LALD/LPN-A stated "[R4's] family requested for [R4] to take aspirin. We did not get a signed order from [R4's] doctor." The licensee's Medication and Treatment Orders-Receiving policy dated August 1, 2021, indicated an RN, LPN, therapist, or person at [licensee name] who is qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber. All orders for medications and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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
01820	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01940	Continued From page 54 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of five residents (R2) 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: During the entrance conference on March 3, 2025, at 11:15 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A confirmed the licensee provided treatment and therapy services to residents as prescribed R2 was admitted on March 1, 2024, with diagnoses to include chronic obstructive pulmonary disease (COPD-chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received assistance with dressing, toileting, bathing, medication management, CPAP, blood sugar monitoring, and insulin injections. On March 3, 2025, at 11:20 a.m., unlicensed personnel (ULP)-C was observed to set up and	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01940	Continued From page 55 administer oral medications, check a blood sugar, and administer insulin to R2. The surveyor noted a Purewick machine on the floor next to R2's bed. The machine was not in use at the time. ULP-C stated it was used during the night and staff assisted R2 with placement of the external catheter and management of the machine. R2's comprehensive assessment dated March 3, 2025, included the use of a Purewick system to assist with urinary incontinence during the night. R2's signed physician's order dated August 27, 2024, indicated use of Purewick system to be used nightly for urinary incontinence. R2's Treatment plan dated March 1, 2025, included the treatments of blood sugar monitoring and CPAP; however, it did not include the Purewick system or the required content of a treatment plan to include: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01940	Continued From page 56 changes. On March 4, 2025, at 1:56 p.m., LALD/LPN-A stated R2's Purewick was considered a treatment as R2 had a written order for it, the unlicensed staff were assisting R2 with proper placement and were managing the maintenance of the equipment. LALD/LPN-A stated R2's treatment plan did not include the Purewick incontinence system. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated for each resident at [licensee name] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. [Licensee name] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed. No further information was provided.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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
01940	Continued From page 57	01940			
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 five residents (R4) with 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	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 58 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: R4 diagnoses included type two diabetes, intellectual disability, obstructive sleep apnea with CPAP (continuous airway positive pressure) use, anxiety, recurrent urinary tract infection with presence of suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received assistance with dressing, grooming, toileting and transfers, medication management, suprapubic catheter maintenance, CPAP management, blood sugar monitoring and insulin administration. On March 3, 2024, at 11:35 a.m., the surveyor observed unlicensed personnel (ULP)-C check R4's blood sugar, administer insulin, and assist with emptying R4's suprapubic catheter. ULP-C stated the staff also assisted R4 with his CPAP at bedtime. R4's signed prescriber's orders dated October 29, 2024, included CPAP to be used each night for R4's obstructive sleep apnea. R4's suprapubic catheter exchange was managed by R4's provider. The licensee's ULP managed catheter care (cleansing the catheter tubing and insertion area at the abdomen) and emptied the urine bag. R4's Treatment plan dated November 6, 2024,	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 59 included the treatments of CPAP management, blood sugar monitoring, and management of R4's suprapubic catheter (catheter care). R4's care plan dated December 6, 2024, included: -CPAP-assist each night with instructions, "See medication administration record (MAR) for cleaning instructions" -Empty catheter bag - days/evenings/night with instructions, "empty two times per shift and as needed-monitor for kinks" R4's record lacked documentation for the treatments of CPAP and suprapubic catheter management. The licensee's RN did not provide direction regarding the management of R4's CPAP (issues with equipment, refusal to wear) and suprapubic catheter management (bloody or cloudy urine, low urine output) that needed to be reported to the nurse. On March 5, 2025, at 2:10 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee had not provide additional information/instruction for the ULP to reference while providing these treatments and would need to address these further with R4's care plan. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated [licensee name] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - documentation of specific resident instructions relating to the treatments or therapy	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901			
(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 60 administration; - 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=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an 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 for two of five residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 61 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: R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD-chronic lung disease), type two diabetes with insulin dependence, chronic back pain, and depression. R2's Service Plan dated February 27, 2025, indicated she received assistance with dressing, toileting, bathing, medication management, CPAP, blood sugar monitoring, and insulin injections. R2's Service Plan lacked the service of Purewick urinary incontinence management. On March 3, 2025, at 11:20 a.m., the surveyor observed unlicensed personnel (ULP)-C set up and administer oral medications, check a blood sugar, and administer insulin to R2. The surveyor noted a Purewick machine on the floor next to R2's bed. The machine was not in use at the time. ULP-C stated it was used during the night and staff assisted R2 with placement of the external catheter and management of the machine. R2's comprehensive assessment dated March 3, 2025, included the use of a Purewick system to assist with urinary incontinence during the night. R2's signed physician's order dated August 27, 2024, indicated use of Purewick system to be used nightly for urinary incontinence.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 62 R2's Treatment plan dated March 1, 2024, lacked the treatment of the Purewick urinary incontinence system. R2's medication administration record (MAR) dated February 2025, included documentation for the treatment of blood sugar monitoring; however, lacked documentation for the treatment of the Purewick system. R2's Resident Cares document dated February 2025, and March 2025, included documentation for various tasks completed by ULP; however, the Resident cares document lacked documentation of the treatment of the Purewick system. On March 4, 2025, at 1:56 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated R2 managed her own CPAP machine; however, R2's Purewick was not on her task record or treatment record for the ULP to document following their assistance in placing it and maintaining it for R2. R4 R4 diagnoses included type two diabetes, intellectual disability, obstructive sleep apnea with CPAP (continuous airway positive pressure) use, anxiety, recurrent urinary tract infection with presence of suprapubic catheter (catheter placement through the abdominal wall into the bladder to empty the bladder). R4's Service Plan dated November 6, 2024, indicated he received assistance with dressing, grooming, toileting and transfers, medication management, suprapubic catheter maintenance, CPAP management, blood sugar monitoring and insulin administration.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 63 On March 3, 2024, at 11:35 a.m., the surveyor observed ULP-C check R4's blood sugar, administer insulin, and assist with emptying R4's suprapubic catheter. ULP-C stated the staff also assisted R4 with his CPAP at bedtime. R4's Treatment plan dated November 6, 2024, included the treatments of CPAP management, blood sugar monitoring, and management of R4's suprapubic catheter (catheter care). R4's care plan dated December 6, 2024, included: -CPAP-assist each night with instructions, "See medication administration record (MAR) for cleaning instructions" -Empty catheter bag- days/evenings/ night with instructions, "empty two times per shift and as needed-monitor for kinks" R4's MAR dated February 2025, and March 2025, included documentation for the treatment of blood sugar monitoring; however, lacked documentation of R4's CPAP management, or suprapubic catheter management. R4's Resident Cares document dated February 2025, and March 2025, included documentation by the ULP for various tasks completed; however, the Resident Cares document lacked documentation of R4's CPAP assistance and management of his suprapubic catheter. The licensee did not document R4's treatments including assistance of R4's CPAP machine and suprapubic catheter. On March 5, 2025, at 2:10 p.m., LALD/LPN-A stated she thought R4's CPAP and suprapubic	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30801	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER WILLOWS & WATERS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 UPPER MEADOW LANE NW ROCHESTER, MN 55901		
(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 64 catheter care was being documented and was not sure why they were not on a treatment record or MAR. The licensee's Treatment and Therapy Plan policy dated August 1, 2021, indicated {licensee name] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -Verification that all treatment and therapy was administered as prescribed No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960			

Type: Full
Date: 03/03/25
Time: 10:13:39
Report: 1038251037

Food and Beverage Establishment Inspection Report

Page 1

Location:

Willows & Waters Senior Living
707 Upper Meadow Lane Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:

ID #: 0037900
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079517887
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

Quaternary Ammonia: = at 100ppm Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 162 Degrees Fahrenheit - Location: Kicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Shredded Cheese
Violation Issued: No

Process/Item: Freezer
Temperature: 0 Degrees Fahrenheit - Location: Vegetables
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Pizza
Violation Issued: No

Process/Item: Freezer
Temperature: 0 Degrees Fahrenheit - Location: Waffles
Violation Issued: No

Type: Full
Date: 03/03/25
Time: 10:13:39
Report: 1038251037
Willows & Waters Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Freezer
Temperature: 0 Degrees Fahrenheit - Location: Bread
Violation Issued: No

Process/Item: Freezer
Temperature: 0 Degrees Fahrenheit - Location: Buns
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Burger
Violation Issued: No

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

willowsandwatersseniorliving@gmail.com

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 1038251037 of 03/03/25.

Certified Food Protection Manager Klint Raverty

Certification Number: FM112685 Expires: 09/06/25

Signed: _____
Establishment Representative

Signed:  _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us