Electronically Delivered
April 17, 2024

Licensee
The Waters Of Edina
6300 Colonial Way
Edina, MN 55436

RE: Project Number(s) SL29647013

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: renee.l.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29647013-0 On April 1, 2024, through April 4, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 76 residents, all of whom received services under the provider's Assisted Living with Dementia Care Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	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	0 630		

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0 630	Continued From page 2 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 identify all areas of vulnerability on the individual abuse prevention plan (IAPP), including statements of the specific measures to be taken by staff to minimize the risk of abuse for two of five residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted on January 30, 2023, with diagnoses to include Parkinson's disease (a chronic and progressive disorder that affect the nervous system, chronic obstructive pulmonary disease (lung disease), arteriosclerotic heart disease, and type 2 diabetes (insufficient production of insulin, causing high blood sugar). R3's signed service plan dated March 15, 2023, indicated R3 received serviced including assistance with meals, housekeeping, laundry,	0 630		

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0 630	Continued From page 3 catheter care, and medication administration. R3 resided with his wife in the secured care unit of the facility. On April 2, 2023, at 8:20 a.m., unlicensed personnel (ULP)-D was observed to provide assistance with catheter cares for R3. R5 R5 was admitted on October 5, 2023, with diagnoses to include traumatic ischemia (restriction of blood supply) of muscle, unspecified severe dementia with other behavioral disturbances, and delirium (medical condition causing severe confusion). R5's signed service plan dated March 30, 2024, indicated R5 received services including assistance with meals, housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, and medication administration. R5 resided in the secured care unit of the facility. R3 and R5's medical record included a Vulnerable Assessment / Abuse Prevention Plan dated May 12, 2023, and September 27, 2023, respectively. Assessment item number 13, "Resident susceptibility to abuse by self or by other individuals, including other residents and other vulnerable adults"; indicated "No." R3 and R5's Vulnerable Assessment / Abuse Prevention Plan lacked an accurate assessment of: -susceptibility to abuse by another individual, including other vulnerable adults. On April 3, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated, R3 and R5 were both considered vulnerable adults and the vulnerability	0 630		

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0 630	Continued From page 4 assessment should have included an accurate assessment of R3 and R5's susceptibility to be abused by self, other individuals, or other vulnerable adults. The licensee's Individual Resident Abuse Prevention Plan policy dated July 29, 2021, included "Vulnerable Adult: A person 18 years of age or older who: -Receives services from an assisted living provider required to be licensed under statute 144A.46; -Regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and -Because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal	0 730		

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0 730	Continued From page 5 representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included accurate documentation that services had been provided as identified in the service plan for two of five residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted on January 30, 2023, with diagnoses to include Parkinson's disease (a chronic and progressive disorder that affect the nervous system), chronic obstructive pulmonary disease (lung disease), heart disease, and type 2 diabetes (insufficient production of insulin, causing high blood sugar). R3's signed service plan dated March 15, 2023, indicated R3 received services including assistance with meals, housekeeping, laundry, catheter care, and medication administration. R3's Service Checkoff List dated March 1, 2024, to March 31, 2024, lacked documentation the following services were provided, or the reason a service was not provided: -March 17, 22, catheter bag change at 8:00 a.m.; -March 11, safety check at 8:00 a.m., 10:00 a.m.;	0 730		

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0 730	Continued From page 7 -March 11-12, safety check at 12:00 p.m.; -March 5, 11-12, safety check at 2:00 p.m.; -March 10, safety check at 4:00 p.m., 6:00 p.m., 8:00 p.m.; and -March 16, 22, catheter bag change at 8:00 p.m. R5 R5 was admitted on October 5, 2023, with diagnoses to include traumatic ischemia (restriction of blood supply) of muscle, unspecified severe dementia with other behavioral disturbances, and delirium (medical condition causing severe confusion). R5's signed service plan dated March 30, 2024, indicated R5 received services including assistance with meals, housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, and medication administration. R5's Service Checkoff List dated March 1, 2024, to March 31, 2024, lacked documentation the following services were provided, or the reason a service was not provided: -March 12, safety check at 12:00 a.m.; -March 3, 5, 9, 19, dressing, grooming, and oral care at 7:30 a.m.; -March 3, 5, 9, 19, safety check at 8:00 a.m.; -March 1, 3, 5, 9, safety check at 10:00 a.m., and 12:00 p.m.; -March 1-3, 5, 9, 21, safety check at 2:00 p.m.; -March 6, 16-17, safety check at 4:00 p.m.; -March 6-7, 16-17, safety check at 6:00 p.m., and 8:00 p.m.; and -March 6-7, 9, 11, 16-17, 28, safety check at 9:55 p.m. On April 3, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated she was aware there was missing documentation for some services	0 730		

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0 730	Continued From page 8 with the licensee's residents, and CNS-B planned to do more education on the importance of service documentation with all employees. The licensee's Resident Health Records policy dated July 7, 2021, included "3. Health and Wellbeing team members will create complete resident health records of all available personal and health related information including: k. documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 9 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for four of five residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2, R3, R4, and R5's records lacked monitoring and reassessment within 14 days from the initial assessment. R2 R2 was admitted December 10, 2021, and received services to include assistance with meals, housekeeping, laundry, catheter care, and medication management. R2's record included an initial comprehensive nursing assessment, dated December 10, 2021, and a subsequent RN reassessment, dated February 10, 2022, (48 days past the 14-day due	01620		

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01620	Continued From page 10 date). R3 R3 was admitted January 30, 2023, and received services to include assistance with meals, housekeeping, laundry, catheter care, and medication management. R3's record included an initial comprehensive nursing assessment, dated January 30, 2023, and a subsequent RN reassessment, dated March 11, 2023, (27 days past the 14-day due date). R4 R4 was admitted February 4, 2021, and received services to include assistance with meals, housekeeping, laundry, bathing, grooming, safety checks, and medication management. R4's record included an initial comprehensive nursing assessment, dated February 4, 2021, and a subsequent RN reassessment, dated February 22, 2021, (five days past the 14-day due date). R5 R5 was admitted October 5, 2023, and received services to include assistance with meals, housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, and medication management. R5's record included an initial comprehensive nursing assessment, dated October 5, 2023, and a subsequent RN reassessment dated November 2, 2023, (five days past the 14-day due date). On April 2, 2024, at 8:20 a.m., unlicensed personnel (ULP)-D was observed to provide assistance with catheter cares for R3. ULP-D	01620		

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01620	Continued From page 11 changed R3's overnight urine bag to a day urine leg bag. -at 9:00 a.m.,ULP-C was observed to administer R2's morning medications. On April 3, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated R2, R3, R4, and R5's 14-day assessments were completed late. The licensee's Comprehensive Resident Assessment, Monitoring, & Reassessment policy, revised July 19, 2021, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640		

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01640	Continued From page 12 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for one of five residents (R2). In addition, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for two of five residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: INITIAL SERVICE PLAN R2 was admitted on December 10, 2021, with diagnoses including coronary arteriosclerosis (a thickening of blood vessels that carry oxygen and nutrients from the heart). R2's initial service plan dated January 31, 2022, indicated R2 received services including assistance with bathing, dressing, grooming and	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	04/04/2024

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01640	Continued From page 13 medication management. R2's record lacked an individualized service plan, prior to January 31, 2022 (52 days after admit), with the required content, and signed by the resident and/or resident representative and licensee representative, indicating the services, frequency of services, fees and individuals who were providing services. SERVICE PLAN REVISIONS R3 R3 was admitted on January 30, 2023, with diagnoses including Parkinson's disease (a chronic and progressive disorder that affect the nervous system), chronic obstructive pulmonary disease (lung disease), heart disease, and type 2 diabetes (insufficient production of insulin, causing high blood sugar). On April 2, 2023, at 8:20 a.m., unlicensed personnel (ULP)-D was observed assisting R3 with catheter cares. R3's signed service plan dated March 15, 2023, indicated R3 received services including assistance with meals, housekeeping, laundry, catheter care, and medication management. R3's service plan, printed April 2, 2024, at 11:02 a.m., during the survey, indicated R3 received the following additional services: dressing, grooming, toileting, transfers, and safety checks. R3's service plan lacked a signature to document agreement with the revisions. R4 R4 was admitted on February 4, 2021, with diagnoses including dementia, depression, and	01640		

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01640	Continued From page 14 osteoporosis. R4's signed service plan dated March 25, 2023, indicated R4 received services including assistance with meals, housekeeping, laundry, bathing, dressing, grooming, safety checks, and medication administration. R4's service plan, printed April 2, 2024, at 11:34 a.m., during the survey, indicated R4 received the following additional services: oral care, toileting, repositioning, and transfers. R4's service plan lacked a signature to document agreement with the revisions. On April 3, 2024, at 9:25 a.m., clinical nurse supervisor (CNS)-B stated, she was aware there were revisions made to R3 and R4's services provided, and those changes were not authenticated by a representative of the licensee and the resident or resident's representative. -12:39 p.m., CNS-B stated they did not finalize R2's initial service plan within 14 days as required. The licensee's Resident Service Plans policy dated July 13, 2021, indicated a finalized service plan would be completed no later than 14 days after initiation of services, and would be reviewed and modified as necessary. The policy further indicated the plan would be signed by the registered nurse and the resident and/or resident designee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01830	Continued From page 15	01830		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 was admitted on February 4, 2021, with diagnoses including dementia, depression, and osteoporosis. R4's signed service plan dated March 25, 2023, indicated R4 received services to include assistance with meals, housekeeping, laundry, bathing, grooming, safety checks, and medication management. R4's medication administration record dated March 2024, and April 2024, indicated R4 received administration of medications which required a current authenticated prescriber order.	01830		

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01830	Continued From page 16 R4's record lacked current signed prescriber orders for all medications R4 received. On April 3, 2024, at 9:45 a.m., clinical nurse supervisor (CNS)-B verbalized she was aware R4's prescriber orders were not current. CNS-B further stated, R4's signed provider orders dated April 3, 2024, had been completed after the survey was initiated. The licensee's Medication Administration - Obtaining Medication Treatment Orders policy dated August 15, 2017, included "Procedure: 1. A prescription is required for all medications including dietary supplements and over-the-counter medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure security and accountability for the overall management, control, and disposition of prescribed and over	01870		

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01870	Continued From page 17 the counter medications for two of six residents (R3, R7). 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: R3 R3 was admitted on January 30, 2023, with diagnoses including Parkinson's disease (a chronic and progressive disorder that affect the nervous system), chronic obstructive pulmonary disease (lung disease), heart disease, and type 2 diabetes (insufficient production of insulin, causing high blood sugar). R3's signed service plan dated March 15, 2023, indicated R3 received services including assistance with meals, housekeeping, laundry, catheter care, and medication management. R7 R7 was admitted on January 30, 2023, with diagnoses including dementia, osteoporosis, and intervertebral disc degeneration, lumbrosacral region (area between the spine and lower back). R7's signed service plan dated March 29, 2023, indicated R7 received services including assistance with meals, housekeeping, laundry, and medication management.	01870		

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01870	Continued From page 18 On April 2, 2024, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-D provide catheter cares for R3. R3 and R7, who were husband and wife, resided in the secured care unit on the first floor in a shared apartment. The surveyor observed two bottles of Advil (for pain) brand medication and one bottle of Miralax (for constipation), unsecured and unattended in R3 and R7's shared bathroom. In addition, there were two ipratropium albuterol sulfate (for wheezing and shortness of breath) inhalers unsecured and unattended, located on the bedside table in R3 and R7's apartment. -at 8:30 a.m., R7 stated she and her husband used these medications occasionally. ULP-D stated he would check with the nurse if these medications were assessed to be allowed to be self administered. R3 and R7's medical records included signed prescriber orders, dated September 28, 2023, and August 2, 2023, respectively. The orders did not include Advil or Miralax, and did not indicate whether R3 and R7 could self-administer medications. R3 and R7's medical records included medication assessments, both dated March 13, 2024. R3 and R7's assessments indicated under Section 6. Medication Management, question number 4, "Does the resident self administer any medications? No". On April 3, 2024, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated medication assessments and prescriber orders for R3 and R7, did not address self-administration of medications. Licensed assisted living director (LALD)-A, also present during the interview, agreed R3 and R7's medications should have	01870		

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01870	Continued From page 19 been secured. The licensee's Individualized Medication Management policy, dated September 13, 2021, included "2. [Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provide;. b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and c. Documentation of specific resident instructions relating to the administration of medications." The licensee's Medication Administration - Obtaining Medication Treatment Orders policy dated August 15, 2017, included "Procedure: 1. A prescription is required for all medications including dietary supplements and over-the-counter medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
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	01940		

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01940	Continued From page 20 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01940		

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01940	Continued From page 21 The findings include: R1 was admitted on December 4, 2023, with diagnoses to including acute kidney failure. R1's service plan dated March 30, 2024, indicated R1 received services to include assistance with catheter care, effective January 16, 2024. On April 2, 2024, at 8:10 a.m., unlicensed personnel (ULP)-C was observed to assist R1 with changing R1's night urine bag to a day urine leg-bag. ULP-C clamped the leg-bag drain, secured the bag to R1's left leg, and disconnected the night bag tubing from the catheter. ULP-C wiped the end of the day bag tubing and the end of the catheter port with an alcohol wipe and joined the sites together. ULP-C took the night bag into the bathroom and rinsed the inside of the bag with a vinegar and water solution. ULP-C hung the bag on a grab bar in the shower and finished assisting R1 with dressing. -at 8:15 a.m., ULP-C stated they had been trained on catheter care by the registered nurse. R1 lacked a treatment management plan with the following required content: -documentation of specific resident instructions relating to the treatment or therapy administration; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services; and -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	01940		

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01940	Continued From page 22 treatment or therapy to prevent possible complications or adverse reactions. On April 3, 2024, at 12:16 p.m., clinical nurse supervisor (CNS)-B stated an individualized treatment plan for R1 had not been created. The licensee's Individualized Treatment & Therapy Management Plan policy, dated September 13, 2021, indicated, "[Licensee] must 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. 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, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970		

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01970	Continued From page 23 electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 was admitted on January 30, 2023, with diagnoses to include Parkinson's disease (a chronic and progressive disorder that affect the nervous system), chronic obstructive pulmonary disease (lung disease), heart disease, and type 2 diabetes (insufficient production of insulin, causing high blood sugar). R3's signed service plan dated March 15, 2023, indicated R3 received services to include assistance with meals, housekeeping, laundry,	01970		

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01970	Continued From page 24 catheter care, and medication administration. On April 2, 2024, at 8:20 a.m., unlicensed personnel (ULP)-D was observed to provide assistance with catheter cares for R3. ULP-D changed R3's overnight urine bag to a daytime urine leg-bag. R3's medical record lacked a current signed order for catheter cares. On April 3, 2024, at 12:42 p.m., clinical nurse supervisor (CNS)-B stated she was not able to find an order for R3's catheter cares. The licensee's Individualized Treatment and Therapy Management Plan policy dated September 13, 2021, included "Procedure: Treatment and therapy orders: 1. There must be an up-to-date written or electronically recorded order from an authorized; 2. The order must contain the following information: name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy; and 3. Treatment and therapy orders must be renewed at least every 12 months." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 25 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for secure storage of chemical liquids. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 2, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D provide catheter care for R3, and medication administration for two residents who resided on the first-floor secured care unit of the facility. On April 2, 2024, at 8:55 a.m., the surveyor observed a bottle of Walgreen's brand nail polish remover and a bottle of Bridgepoint Stain Zone Oxidizing stain remover in an unlocked cabinet in the secured care unit on first floor staff area. The staff area had two half doors in the open position. ULP-D stated, all the cabinets in the staff area, where the half doors are kept open should always be locked, as the residents have access to all areas of the secured care area. ULP-D stated	02310		

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02310	Continued From page 26 someone must have forgotten to lock the cabinets, and ULP-D proceeded to lock all the cabinets in the staff area. -11:20 a.m., registered nurse case manager (RNCM)-F stated, the cabinets in the staff area that had the nail polish and stain remover should be kept locked when not being used. On April 3, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated the nail polish and stain remover on first floor secured care unit should have been in a locked cabinet. The Oxidizing Stain Remover Material Safety Data Sheet (MSDS) dated February 14, 2022, indicated, "Classification, [occupational safety and health administration (OSHA)] Regulatory Status. This chemical is considered hazardous by the 2012 OSHA Hazard Communication Standard (29 CFR 1910.1200)." In addition, the MSDS indicated, "Warning, Hazard Statements: -Harmful if inhaled -Causes skin irritation -Causes serious eye irritation." The MSDS further indicated, "7. Handling and Storage, keep container tightly closed in a dry and well-ventilated place. Keep out of the reach of children. Keep containers tightly closed in a cool, well-ventilated place. Keep away from heat and sources of ignition. Keep in properly labeled containers. Keep away from heat." The Nail Polish Remover MSDS dated December 21, 2012, indicated, "2. Hazards Identification, Classification: -Serious eye damage/eye irritation - Category 2; -Specific target organ toxicity (single exposure) - Category 3; and -Flammable liquids - Category 2"	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the steps of the medication administration process were followed for one of five residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses included dementia. R6's service plan printed November 30, 2023, indicated R6 received services to include	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(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
02320	Continued From page 28 assistance with medication administration. R6's prescriber orders dated October 3, 2023, included orders for polyethylene glycol (Miralax) powder, 17 grams (g). On April 2, 2024, at 8:45 a.m., unlicensed personnel (ULP)-C was observed to punch out R6's morning medications from a bubble pack, crush them in a medication crusher, place them into a medication cup, and mix them into a spoonful of applesauce. ULP-C then dissolved 17 g of Miralax powder in eight ounces of water. ULP-C brought the medications mixed with applesauce and the glass of dissolved Miralax powder to R6 who was sitting in the commons area. ULP-C used a spoon to put the medications mixed with apple sauce into R6's mouth and gave R6 a drink from the glass containing the dissolved Miralax. ULP-C offered R6 another drink from the glass, then placed the remainder of the glass with Miralax onto an end table next to R6. ULP-C returned to the medication cart, punched out medications for R2, and brought R2's medications to her in her apartment. The surveyor observed the glass of dissolved Miralax sitting unattended on the end table next to R6. On April 2, 2024, at 9:20 a.m., ULP-C stated they should not have left the glass with dissolved Miralax unattended on the end table next to R6. ULP-C further stated they should have administered medications to one resident at a time. On April 2, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated, staff should not leave medications unattended with residents and should give medications to one resident at a time.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(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
02320	Continued From page 29 The licensee's Administration of Medication policy, dated September 13, 2021, indicated medications were to be set up and administer to one resident at a time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *04/01/24*
Time: 13:00:00
Report: 1013241033

Food and Beverage Establishment Inspection Report

Location:
The Waters Of Edina
6300 Colonial Way
Edina, MN55436
Hennepin County, 27

Establishment Info:
ID #: 0038773
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523227500
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

COLD TCS FOOD WAS STORED AT ROOM TEMP IN AN ICE BATH ON THE COOK LINE: SLICED WATERMELON 48F, COLESLAW 50F. PER STAFF, FOOD WAS REMOVED FROM TEMP CONTROL 2HR 20MIN PRIOR. DISCUSSED COLD HOLDING PROCEDURES WITH STAFF AND FOOD TIME TAGGED TO BE DISCARDED.

Comply By: 04/01/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12E

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

A CUP WITHOUT A HANDLE WAS STORED DIRECTLY IN THE ICE LOCATED IN THE SATELLITE KITCHEN ICE BIN. COMPLY WITH ABOVE RULE. DISCUSSED ICE SCOOP USE WITH STAFF AND THE CUP WAS REMOVED.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

FOOD BUILD UP WAS ON THE BOTTOM INSIDE OF THE KITCHEN ICE CREAM FREEZER. GRIME AND DEBRIS BUILD UP WERE ON THE INSIDE DOORS OF THE LARGE DISH MACHINE. DISCUSSED CLEANING PROCEDURES WITH STAFF AND REQUESTED EQUIPMENT BE CLEANED.

Comply By: 04/01/24

4-900 Protecting Clean Items

4-901.11

MN Rule 4626.0935 Allow equipment and utensils to air-dry after cleaning and sanitizing; only use cloths that are clean and dry for polishing utensils that have been air dried.

FOOD CONTAINERS WERE WASHED, THEN STORED WET AND NESTED IN THE DRY STORAGE ROOM. DISCUSSED WARE WASHING PROCEDURES AND STAFF MOVED THE CONTAINERS TO ALLOW THEM TO AIR DRY.

Corrected on Site

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

SINGLE-SERVICE KNIVES, SPOONS, AND FORKS WERE DISPLAYED IN BASKETS WITH THE HANDLES AND MOUTH CONTACT SIDES COMMINGLED LOCATED IN THE CAFE. DISCUSSED UTENSIL DISPLAY WITH STAFF. UTENSILS WERE REARRANGED SO ONLY HANDLES WERE CONTACTED BY THE CUSTOMER.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASHING SIGN/POSTER WAS AVAILABLE AT THE SATELLITE KITCHEN HAND WASHING SINKS. COMPLY WITH ABOVE RULE.

Comply By: 04/05/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

FOOD DEBRIS AND TRASH BUILD UP WERE ON THE FLOOR BELOW THE LARGE DISH MACHINE. COMPLY WITH ABOVE RULE. DISCUSSED CLEANING PROCEDURES WITH STAFF.

Comply By: 04/01/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer - cafe area
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - cook line
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - prep area
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Large dish machine
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Small dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Satellite kitchen refrigerator
Violation Issued: No

Process/Item: Egg salad
Temperature: 34 Degrees Fahrenheit - Location: Cafe prep cooler
Violation Issued: No

Process/Item: Tuna salad
Temperature: 32 Degrees Fahrenheit - Location: Cafe prep cooler
Violation Issued: No

Process/Item: Sliced melon
Temperature: 30 Degrees Fahrenheit - Location: Cafe display cooler
Violation Issued: No

Process/Item: Salmon
Temperature: 39 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Beef
Temperature: 39 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Milk
Temperature: 31 Degrees Fahrenheit - Location: Server cooler
Violation Issued: No

Process/Item: Soup
Temperature: 155 Degrees Fahrenheit - Location: Warmer
Violation Issued: No

Process/Item: Chicken
Temperature: 168 Degrees Fahrenheit - Location: Warmer
Violation Issued: No

Process/Item: Chicken
Temperature: 38 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Type: Full
Date: *04/01/24*
Time: 13:00:00
Report: 1013241033
The Waters Of Edina

Food and Beverage Establishment Inspection Report

Process/Item: Sliced tomatoes
Temperature: 40 Degrees Fahrenheit - Location: Cold top cooler
Violation Issued: No

Process/Item: Coleslaw
Temperature: 50 Degrees Fahrenheit - Location: Ice bath at room temperature
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	6

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator T. Carlson.

Discussed staff illness policy, ware washing, sanitizer, cleaning, serving a highly susceptible population, temperature control, cook temperatures, hand washing, and food handling procedures.

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 1013241033 of 04/01/24.

Certified Food Protection Manager: Nichel Lubecke

Certification Number: 102072 Expires: 10/25/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Nichel Lubecke
Assistant Director

Signed: JM

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us