Electronically Delivered

March 7, 2023

Licensee
The Waters Of Highland Park
678 Snelling Avenue South
Saint Paul, MN 55116

RE: Project Number(s) SL31949015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Paul Spencer, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: paul.spencer@state.mn.us
Phone: 651-587-4460 | Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31949	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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 ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 31949015 On January 31, 2023, 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 and investigation, there were 74 residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Assisted Living Provider 144G. 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 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.	

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0 480	Continued From page 1	0 480		
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 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 included document titled, Food and Beverage Establishment Inspection Report dated January 31, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 2 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; (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 all required content for three of six employees, and executive director (ED)-A (signed performance evaluation), unlicensed personnel (ULP)-F and licensed practical nurse (LPN)-H, (signed performance evaluation) with employee records reviewed. 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	0 650		

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0 650	Continued From page 3 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: ED-A's employee file indicated the licensee hired ED-A on April 5, 2021. A review of a document titled 2022 Reviews, Review Period 6/1/2021 to 5/31/22 indicated it was neither signed by the employee or a reviewer. Although requested, the licensee provided no other review for ED-A. On February 1, 2023, at approximately 8:30 a.m., ULP-F was observed passing medications to the assisted living residents. ULP-F's employee record indicated the licensee hired ULP-F November 30, 2018. A review of ULP-F's employee record did not identify evidence of periodic supervision of delegated activities. LPN-H's employee records indicated the licensee hired LPN-H on January 27, 2022. LPN-H's employee records included a document titled 2022 Common Review Feedback, however a review of this document found it form undated, and unsigned. The same form indicated an overall rating of consistently performs to The Waters Expectations, but the goals portion of the document remained blank. The licensee's policy titled Team Member Records dated April 2021, indicated the facility will maintain team member records according to	0 650		

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0 650	Continued From page 4 state and federal regulation. During an interview on February 2, 2023, at approximately 12:30 p.m., ED-A confirmed the files did not have the required information. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that emergency preparedness manual contained the most current contact personnel names and phone numbers. In addition, the licensee failed to perform the monthly load test runs and weekly inspections of the emergency power generator to meet the requirements outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. This had the potential to affect all residents and staff in the facility. 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 had a current assisted living facility with dementia care license. On February 1, 2023, at approximately 3:45 p.m., document review and interview with the licensed assisted living director (LALD)-A and the environmental services director (ESD)-B, survey staff requested records relating to the emergency generator inspections, maintenance, and load	0 680		

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0 680	Continued From page 6 test runs for review. No generator records were available or provided for review, but the ESD-B stated that they will look into retrieving printouts from the generator log. On February 1, 2023, at approximately 3:45 p.m., the licensee failed to meet the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: -Required weekly inspections of the generator systems. -Required monthly generator load tests. -Required monthly transfer switch operation tests. On February 1, 2023, at approximately 4:00 p.m., during the exit interview, the ESD-B and the LALD-A acknowledged the above findings. Survey staff noted that additional generator documentation will be honored if received by end of February 2, 2023. Additional documentation was received via email on February 3, 2023, at 12:23 p.m. by the LALD-A for a 4-hour load run report provided by a contractor, dated February 25, 2022. No other records of generator tests or inspections were received. On February 2, 2023, during review of the facility emergency preparedness manual it was noted that the name of the previous directors of health and wellbeing was listed under emergency contact information on the main phone list and on the tab labeled Rapid Response Guides.	0 680		

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0 680	Continued From page 7 On February 3, 2023, at approximately 12:15 p.m., the executive director acknowledged the EP manual would be updated to reflect the most current employee contact information. The licensee's Emergency policy indicated the policy was available for the steps to follow if a potential or actual emergency my threaten the safety of the occupants of the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 8 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection of smoke alarms inside the resident apartment unit 224 and the combined apartment unit 415/417. This has the potential to directly affect the residents in these units receiving assisted living care. 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: On February 1, 2023, approximately from 11:30 a.m. to 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-B. During the tour, survey staff observed the following: 1. In the one-bedroom apartment unit 224, the required smoke alarms were not interconnected. The finding was evident when the ESD-B tested the smoke alarms by activating each smoke alarm and each sounded local and failed to sound the other smoke alarm. The ESD-B confirmed the finding. 2. Apartment units 415 and 417 were remodeled by combining the two studio-type apartment units into one apartment unit by installing a set of	0 780		

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0 780	Continued From page 9 connecting sliding doors to the bedroom. The smoke alarms were tested by the ESD-B and were not interconnected to sound throughout as required. The finding was evident when the ESD-B tested the smoke alarms and each sound locally. Survey staff explained to the ESD-B that the remodeled combined studios are now considered as one apartment unit and the smoke alarms inside the apartment unit must be interconnected so both smoke alarms would sound when one alarm is activated in the apartment unit for compliance with statutes. On February 1, 2023, at approximately 4:00 p.m., during the exit interview, the ESD-B and the licensed assisted living director-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents	0 800		

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0 800	Continued From page 10 and staff. 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 February 1, 2023, approximately from 11:30 a.m. to 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-B. During the tour, survey staff observed and the ESD-B verified the following: 1. The filters for the wall-mounted cooling and heating units inside the resident apartments 403, 425, and 431 were filled with dust. The ESD-B confirmed the findings. 2. In resident apartment units 409, 415/417, 431, and 432, spray and/or toilet bowl cleaning chemicals were accessible to the residents under their cabinets that posed safety concerns due to misuse of those products. 3. In unit 415/417, a full-size mattress was stored in the bathroom that covered the shower compartment completely. The placement of the mattress poses concerns about the mattress falling over and the lack of maintenance of the unused shower trap/drain to prevent sewer gas from entering the environment. 4. In resident room 123, the toilet paper holder was broken.	0 800		

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0 800	Continued From page 11 5. The chemical soap dispenser connected to the faucet of the mop sink located on the main floro level was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. On February 1, 2023, at approximately 4:00 p.m., during the exit interview, the ESD-B and the licensed assisted living director (LALD)-A acknowledged the above findings. Additional documentation was received via email from the LALD-A on Friday 02/03/2023 at 12:23 p.m. on the carpeting cleaning log. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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) employee 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) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 12 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide complete content of the fire safety and evacuation plan and the correct frequency of employee evacuation drills. This has the potential to directly affect the safety of all residents receiving services, 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 the potential to affect a large portion or all of the residents). The findings include: On February 1, 2023, at approximately 2:45 p.m., survey staff reviewed the facility fire safety and evacuation plan and related documentation	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31949	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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 13 received from the licensed assisted living director (LALD)-A. At approximately 3:45 p.m., document review and interview with the LALD-A and the environmental services director (ESD)-B, indicated the evacuation floor layouts for each 1st, 2nd, and 3rd floor posted near the elevator lobby of those floors lacked location and numbers of sleeping rooms. In addition, survey staff requested for evacuation floor layout for the 4th floor and one was not available or posted. During the interview, the LALD-A and the ESD-B confirmed that the fire safety and evacuation plan for the facility lacked these provisions and needed to be updated with the current plans. On February 1, 2023, at approximately 4:00 p.m., during the exit interview, the ESD-B and the LALD-A acknowledged the above findings. Survey staff also explained that an evacuation plan layout needs to include and identify all smoke barrier locations for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01450 SS=F	144G.62 Subd. 5 Documentation A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of direct supervision of staff by a registered nurse (RN) performing delegated tasks for one of three unlicensed personnel (ULP)-F	01450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31949	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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
01450	Continued From page 14 with records reviewed. 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 the residents). The findings include: ULP-F was hired on November 30, 2018, under the licensee's comprehensive home care license. ULP-F began providing assisted living services to licensee's residents after August 1, 2021. On February 1, 2023, at approximately 8:30 a.m., ULP-F was observed passing medications to assisted living residents. ULP-F's record lacked evidence of documentation that an RN supervised ULP-F performing delegated tasks in accordance with assisted living statutes beginning August 1, 2021. Policy titled Supervision, Training and Competency of Delegated Nursing services, Treatments or Therapy tasks, undated, indicated upon successful completion of training as demonstrated by written or oral test the RN performs a skills competency evaluation (supervision) of the ULPs ability to safely perform the delegated task. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31949	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

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01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received the required amount of dementia care training in the required period for two of four employees, executive director (ED)-A and registered nurse (RN)-E records reviewed. 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	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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
01540	Continued From page 16 found to be pervasive). The findings include: The licensee had a current assisted living facility with dementia care license. ED-A's employee record indicated the licensee hired ED-A on April 5, 2021. The same documents included a certificate for completion of training, titled "essentiALZ" for 3 hours on July 7, 2021. The same documents included a certificate for The Waters dementia training dated October 12-13, 2022. A review of ED-A's employee record did not identify documentation of ED-A's completion of the required eight (8) hours of training on the specific dementia care topics within 80 working hours of the licensure requirement which began August 1, 2021. On February 2, 2023, at approximately 12:30 p.m., ED-A confirmed she had not completed the above noted dementia training within the required timeline. RN-E's employee records indicated the licensee hired RN-E on August 8, 2022. On January 31, 2023, at approximately 11:45 a.m., during the facility tour, RN-E was observed interacting and providing services for a resident in her office. Review of RN-E ' s Relias transcripts indicated the following hours between August 11-17, 2022: A Day in the life of Henry: A dementia experience,	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31949	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

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01540	Continued From page 17 0.25 hours. Dementia Care: Activities for people with memory problems, 0.50 hours. Dementia Care: Ethical Considerations, 0.50 hours. Dementia Care: Helping family and friends, 1.00 hour. Dementia Care: Normal aging vs. Dementia/Alzheimer ' s, 0.50 hours. Dementia Care: Understanding Alzheimer ' s disease, 0.50 hours. Dementia Care: Understanding Communication, 0.50 hours. Parkinson ' s Dementia: 0.25 hours. Providing High Quality Dementia Care - An overview, 1.00 hour. RN-E's employee record did not contain documentation RN-E completed the required eight (8) hours of training for a direct care employee on the specific dementia care topics within 80 working hours of hire date for the licensure requirement that began August 1, 2021. On February 3, 2023, at approximately 12:15 p.m., RN-E confirmed she may have not completed the above noted dementia training as required. RN-E stated that if she found other training, she would complete it. The licensee's Orientation and Annual Training policy dated April, 2021, noted direct care employees of assisted living with dementia care licensed facilities would complete eight hours of initial training within 80 hours of the employment start date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01540		

DEPARTMENT OF HEALTH

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

Type: Full
Date: *01/31/23*
Time: 12:00:00
Report: 1031231016

Food and Beverage Establishment Inspection Report

Location:
The Waters Of Highland Park
678 Snelling Avenue South
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0038708
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513633040
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 02/06/23

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

MULTIPLE FOOD ITEMS FOUND STORED UNDER SHELVING IN WALK-IN FREEZER. MOVE ITEMS TO SHELVING.

Comply By: 02/03/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

MEM CARE GE REFRIGERATOR MISSING MULTIPLE PARTS ON DOOR FRONT. REPLACE PARTS OR REPLACE REFRIGERATOR.

Comply By: 04/26/23

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

TOP CONVECTION OVEN HAS BUILDUP OF FOOD DEBRIS ON DOORS, RACKS, AND WALLS. CLEAN AND MAINTAIN CLEAN.

Comply By: 02/15/23

4-600 Cleaning Equipment and Utensils

4-602.12

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

INTERIOR OF MICROWAVE (MEM CARE FOH) HAS SPLATTERS OF FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 02/08/23

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.

FLAT TOP AND DRAWER COOLER UNDER FLAT TOP HAVE FOOD DEBRIS/SPLASHES/GREASE ON FRONT AND SIDES. CLEAN AND MAINTAIN CLEAN.

Comply By: 02/15/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

TILE(S) IN FRONT OF CONVECTION OVEN CRACKED IN MULTIPLE PLACES. REPLACE TILE.

Comply By: 04/26/23

Surface and Equipment Sanitizers

Hot Water: = 200 at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: No

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

Ambient Air Temp: = at 38 Degrees Fahrenheit
Location: Delfield Soda Cooler
Violation Issued: No

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

Ambient Air Temp: = at 41 Degrees Fahrenheit
Location: Soda Cooler (mem)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Tuna Salad
Temperature: 38 Degrees Fahrenheit - Location: Hoshi Upright Reach-in Cooler
Violation Issued: No

Process/Item: Hot Hold/Veg Soup
Temperature: 168 Degrees Fahrenheit - Location: Soup Warmer (expo)
Violation Issued: No

Process/Item: Cold Hold/Pinapple
Temperature: 41 Degrees Fahrenheit - Location: Norlake 1-Door Reach-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Strawberries
Temperature: 41 Degrees Fahrenheit - Location: Norlake 1-Door Reach-in Cooler
Violation Issued: No

Process/Item: Hot Hold/Veg Soup
Temperature: 176 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Hot Hold/Veg Soup
Temperature: 190 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cold Hold/Tomatoes; Diced
Temperature: 37 Degrees Fahrenheit - Location: Prep Table (cook line)
Violation Issued: No

Process/Item: Cold Hold/Noodles
Temperature: 37 Degrees Fahrenheit - Location: Prep Table (cook line)
Violation Issued: No

Process/Item: Cold Hold/Sauerkraut
Temperature: 36 Degrees Fahrenheit - Location: Under Char Drawer Cooler
Violation Issued: No

Process/Item: Cold Hold/Salmon
Temperature: 37 Degrees Fahrenheit - Location: Under Char Drawer Cooler
Violation Issued: No

Process/Item: Cooking/Soup
Temperature: 196 Degrees Fahrenheit - Location: Oven
Violation Issued: No

Process/Item: Cold Hold/Beets
Temperature: 36 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Burger Patty
Temperature: 41 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Cheesy Hashbrown
Temperature: 36 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Celery
Temperature: 38 Degrees Fahrenheit - Location: GE Refrigerator
Violation Issued: No

Process/Item: Hot Hold/Saus & Potatoep
Temperature: 173 Degrees Fahrenheit - Location: Steam Table (mem)
Violation Issued: No

Process/Item: Hot Hold/Hot Sandwich
Temperature: 175 Degrees Fahrenheit - Location: Steam Table (mem)
Violation Issued: No

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

Inspection conducted by Chris F, in the presence of Chris E.

All violations discussed with Chris After inspection.

NOTE: Veg wash not in service/not used*

Discussed:
- Illness and illness log
- Facilities upkeep and maintenance
- Handwashing and glove use
- Thermometer use

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

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

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031231016 of 01/31/23.

Certified Food Protection Manager Christian J Erickson

Certification Number: FM101003 Expires: 10/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Christian J Erickson
Person in Charge

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

Report #: 1031231016

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1	Date	01/31/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
The Waters Of Highland Park	678 Snelling Avenue South	St Paul, MN	55116	6513633040

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038708		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	(IN) OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/01/23

Inspector (Signature)