



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 10, 2025

Licensee
Wealshire of Medina
4555 Mohawk Drive
Medina, MN 55340

RE: Project Number(s) SL33609016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

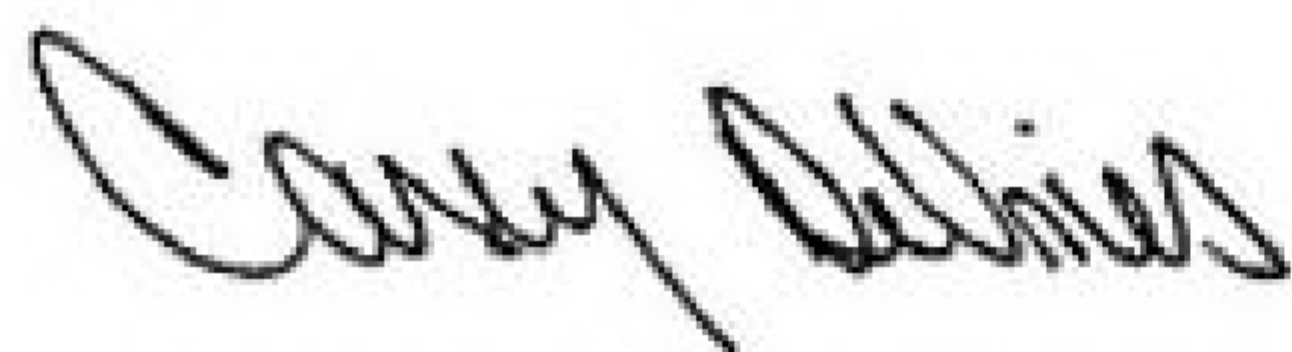
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33609	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER WEALSHIRE OF MEDINA			STREET ADDRESS, CITY, STATE, ZIP CODE 4555 MOHAWK DRIVE MEDINA, MN 55340		
(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: SL33609016-0 On March 10, 2025, through March 12, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 71 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 775	Continued From page 1 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 March 11, 2025, from approximately 1:33 p.m. to 4:10 p.m., the surveyor toured the facility with director of maintenance (DM)-F and maintenance (M)-G and observed the following deficient conditions: One of several gates from outdoor patio in Northwest corner of property with shuffleboard court to the public right of way was not operable during time of inspection and was secured shut with a wire cable. This gate represents part of a component of egress from the facility and must be maintained in functional order and should be capable of allowing egress from courtyard. DM-F and M-G acknowledged the gate was not functional, obstructing potential egress and stated	0 775			

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0 775	Continued From page 2 that repairs to the gate are in the works. Several discarded cigarettes were present on the ground in the employee outdoor patio. M-G stated that the recently melted snow had exposed these cigarette butts and that they would be removed and properly disposed of. DM-F and M-G stated that they understood requirements for proper disposal of smoking and would remind staff to appropriately dispose of cigarettes in provided approved containers. The fire door rating information labels were covered up by paint on fire doors in hallway outside of employee offices and in basement outside of medical supply room. Fire door rating labels should be maintained and remain exposed to display fire rating of the assembly. Fire caulking was degraded and missing around wiring in the medical supply closet in the basement. DM-F and M-G stated the caulking would be reapplied to the opening. During the survey, the surveyor explained requirements and noted deficient conditions in the facility. DM-F and M-G acknowledged the deficiencies during survey and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
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:	0 810			

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0 810	Continued From page 3 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810			

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0 810	Continued From page 4 safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 11, 2025, at approximately 3:40 p.m., director of maintenance (DM)-F and maintenance (M)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP did not include sufficient fire drills. Records titled Fire Drill Report were provided during interview which included only drills conducted on 11/12/24, 11/8/24, 11/6/24, 10/18/24, and 10/30/24. The surveyor inquired about additional fire drills and DM-F stated that they would email them by early the next morning. On 3/12/25 DM-F supplied Fire Drill Report via email including additional fire drills conducted at the facility on 12/5/24, 12/4/24, and 4/19/24. The surveyor explained to DM-F that fire drills are required twice per shift per year and at least once every other month. DM-F stated their misunderstanding, having been unaware of a requirement to conduct drills every other month and as a result not having appropriate records. DM-F acknowledged requirements and indicated they would implement appropriate drills in the future. During the record review and interview on March	0 810			

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0 810	Continued From page 5 11, 2025, as well as in subsequent communication on March 12, 2025, DM-F verified the above listed documents were absent from the FSEP. DM-F stated that they understood requirements for drills, and they would develop an appropriate policy to conduct and record fire drills at least twice per year per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950			

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0 950	Continued From page 6 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative in writing and the contract to include the following verbatim notice on a document separate from the contract: "Right to Designate a Representative For Certain Purposes" notice for two of four residents (R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R3 R3 was admitted to the licensee on February 1, 2023, for assisted living services. R3's Resident Agreement was signed on January 23, 2023. R4 R4 was admitted to the licensee on July 18, 2023, for assisted living services. R4's Resident Agreement was signed on July 6,	0 950			

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0 950	Continued From page 7 2023. R3 and R4's Resident Agreement lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On March 12, 2025, at 1:31 p.m., clinical nurse supervisor (CNS)-A stated the licensee was aware of the requirement. CNS-A also stated the licensee updated their resident agreement, however, residents who were already admitted had not had theirs updated to the licensee's new resident agreement. The licensee's undated Contracts policy indicated each prospective resident will be provided a contract that must be signed before housing our services begin. The policy lacked the verbiage to include to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:	01060			

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01060	Continued From page 8 (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated	01060			

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01060	Continued From page 9 representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (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: R5 was admitted to the licensee on July 24, 2024, for assisted living services. R5's Service Plan dated July 18, 2024, indicated R5 received the following services: medication administration, medication ordering and refills, communication with providers, assessments, bathing, dressing, laundry, linen change, and light housekeeping. R5's Nurse's Note dated March 4, 2025, indicated R5 had a fall in the bathroom and was taken to the hospital via emergency medical services. R5's Nurse's Note dated March 5, 2025, indicated R5 was admitted to hospital for rib fracture and pneumothorax. On March 10, 2025, at 10:04 a.m., during the entrance conference clinical nurse supervisor (CNS)-A stated R5 was still in hospital. CNS-A also stated they were unaware of the requirement for an emergency relocation notice.	01060			

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01060	Continued From page 10 The licensee's undated Emergency Relocation policy indicated if a resident was out of the facility due to an emergency relocation and had not returned within 4 days, the licensee will notify the resident, the legal representative, the designated representative and the Office of Ombudsman for Long Term Care within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			



Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: 03/11/25
Time: 14:00:00
Report: 8087251040

Food and Beverage Establishment Inspection Report

Page 1

Location:

Wealshire Of Medina
4555 Mohawk Drive
Medina, MN55340
Hennepin County, 27

Establishment Info:

ID #: 0038087
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634751900
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Wash Temperature Gauge: = -- at 155 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 188 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -4 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Type: Full
Date: 03/11/25
Time: 14:00:00
Report: 8087251040
Wealshire Of Medina

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: BEEF STEW
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER SHIELA MILLER.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO NURSING EVALUATOR BENARD NYANGENA.

Type: Full
Date: 03/11/25
Time: 14:00:00
Report: 8087251040
Wealshire Of Medina

Food and Beverage Establishment Inspection Report

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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 8087251040 of 03/11/25.

Certified Food Protection Manager SUSAN M. STUEFEN

Certification Number: FM39584 Expires: 06/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

SHIELA MILLER
KITCHEN MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
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