Electronically Delivered

April 9, 2025

Licensee
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN 55110

RE: Project Number(s) SL30557016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30557	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30557016-0 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 26 residents; 26 receiving services under the Assisted Living Facility 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-E, ULP-F). 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	0 660		

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0 660	Continued From page 4 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: RN-D RN-D was hired on July 8, 2024, and provided direct nursing cares to residents. RN-D's employee record included a TB history and symptom screening form dated July 6, 2024, indicating no previous adverse reaction to a tuberculin skin test (TST). The record included a negative first step TST dated July 9, 2024. RN-D's record lacked documentation of a second step TST. ULP-E ULP-E was hired on November 6, 2023, and provided direct cares to residents. ULP-E's employee record included a TB history and symptom screening form dated November 6, 2023, indicating no previous adverse reaction to a TST. The record included a negative chest x-ray dated March 29, 2023. ULP-E's record lacked documentation of a positive TB blood test or TST correlated to the chest x-ray, or a TB blood test or TST completed within 90 days prior to hire date. ULP-F ULP-F was hired on November 11, 2024, and provided direct cares to residents. On February 24, 2025, at 11:35 a.m., the surveyor observed ULP-E assist R2 with blood glucose testing. ULP-F's employee record included a TB history	0 660		

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0 660	Continued From page 5 and symptom screening form dated November 12, 2024, indicating no previous adverse reaction to a TST. The record included a negative first step TST dated November 14, 2024. ULP-F's record lacked documentation of a second step TST. On February 25, 2025, at 2:09 p.m., licensed assisted living director (LALD)-A stated, via email, "We do not have 2-steps for RN-D and ULP-F." On February 25, 2025, at 2:29 p.m. LALD-A stated, via email, "Yes, we are aware that 2 step is a requirement." On February 26, 2025, at 9:38 a.m., LALD-A stated she was not aware a previously documented positive TB test was required to be in ULP-E's employee record in addition to the follow up chest x-ray. LALD-A stated she planned to follow up with ULP-E. The licensee's 8.1 Tuberculosis Screening policy dated August 1, 2021, indicated, "[Licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR)." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease;	0 660		

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0 660	Continued From page 6 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. In addition, indicated a HCW with written documentation of a previous positive TST or IGRA. If the test is appropriately documented, you do not need to repeat the test. Before the HCW has direct patient contact, the following should be documented in their record: 1. Test result; 2. Assessment for current TB symptoms; 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease, or a clinician recommends a repeat chest X-ray; and 4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 7 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 provide egress windows in compliance with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 25, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A, director of operations (DO)-C, and maintenance (M)-G. The following was observed. While testing smoke alarm in resident room 113 M-G had removed hard wired smoke alarm from the ceiling as it appeared to not be properly secured. M-G stated that the manufacture date on the alarm was 2006. It was observed that a majority of smoke alarms in the facility appeared to be the same make and age. Smoke alarms shall be tested and maintained in accordance with the manufacturer's instructions. Smoke alarms shall be replaced when they fail to	0 775		

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0 775	Continued From page 8 respond to operability tests, or when they exceed 10 years from the date of manufacture, unless an earlier replacement is specified in the manufacturer's published instructions. In resident room 114 it was observed that there were hard wired smoke alarms installed in the living room and an additional hard wired smoke alarm in the bedroom. The original hard wired smoke alarm in the bedroom was not interconnected with the newer interconnected smoke alarms. M-G stated that they believe all of the one-bedroom units have similar smoke alarm configurations. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. The emergency light in the first-floor hallway between resident rooms 106 and 107 would not operate when tested. The emergency power system shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 9 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Department of Health and Human Services (DHS) background study, associated with the licensee's health facility identification number (HFID) 30557 for two of two unlicensed personnel ((ULP)-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired November 6, 2023, and provided direct cares services to the residents. On February 24, 2025, at 11:35 a.m., the	01290		

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01290	Continued From page 10 surveyor observed ULP-E assist R2 with blood glucose testing. ULP-E's employee record contained documentation of a cleared DHS background study form dated November 5, 2023, however the background study had been submitted through a separate location, HFID 34601, also operated by the licensee's owner. ULP-E's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 30557. On February 24, 2025, at 1:10 p.m., director of operations (DO)-C provided, via email, an updated DHS background study clearance form for ULP-E, affiliated with the licensee HFID 30557, dated February 24, 2025, during the survey. ULP-F ULP-F was hired November 11, 2024, and provided direct cares services to residents. On February 24, 2025, at 11:35 a.m., the surveyor observed ULP-F assisting a resident with a walker to the dining area of the secured care area. ULP-F's employee record contained documentation of a cleared DHS background study dated January 17, 2025, however, the background study had been submitted through a separate location, health facility identification (HFID) 32276, also operated by the licensee's owner. ULP-F's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 30557.	01290		

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01290	Continued From page 11 On February 24, 2025, at 1:28 p.m., DO-C provided, via email, an updated DHS background study clearance form for ULP-F, affiliated with the licensee HFID 30557, dated February 24, 2025, during the survey. On February 24, 2025, at 1:35 p.m., licensed assisted living director (LALD)-A and DO-C stated, ULP-E, ULP-F, and three other employees on the DHS NETStudy background study roster were affiliated only to other [Licensee] facilities, and those employees were updated and affiliated with HFID 30557, during the survey. The licensee's 4.02 Background Studies policy dated May 3, 2023, indicated "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30557	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(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
01610	Continued From page 12 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial nursing assessment prior to signing the assisted living contract and providing services for one of three residents (R2). 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: On February 24, 2025, at 11:35 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with blood glucose testing.	01610		

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01610	Continued From page 13 R2 was admitted on June 26, 2023, and had diagnoses including Alzheimer's disease (memory loss), type two diabetes (a long-term condition in which the body has trouble controlling blood sugar), and a history of seizures (abnormal electrical activity in the brain). R2's Service Plan - Waiver3 - MN, dated February 6, 2025, indicated R2 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, blood glucose testing, and medication administration. R2's record lacked an initial nursing admission assessment completed by a registered nurse of the physical and cognitive needs of the prospective resident prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. On February 25, 2025, at 12:40 p.m., licensed assisted living director (LALD)-A stated, via email, they did not have an initial RN assessment for R2. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated September 5, 2024, "[Licensee] will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01610	Continued From page 14 (21) days	01610		
01620 SS=D	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 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 the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for two of three residents (R2, R4).	01620		

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01620	Continued From page 15 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: On February 24, 2025, at 10:14 a.m., during the entrance conference, licensed assisted living director (LALD)-A, and director of operations (DO)-C stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 R2 was admitted on June 26, 2023, and had diagnoses including Alzheimer's disease (memory loss), type two diabetes (a long-term condition in which the body has trouble controlling blood sugar), and a history of seizures (abnormal electrical activity in your brain). On February 24, 2025, at 11:35 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with blood glucose testing. R2's Service Plan - Waiver3 - MN, dated February 6, 2025, indicated R2 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, blood glucose testing, and medication administration.	01620		

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01620	Continued From page 16 R2's medical record lacked an initial comprehensive RN assessment, and a subsequent nursing assessment within 14-days after start of services. On February 25, 2025, at 12:40 p.m., LALD-A stated, via email, they did not have a 14-day assessment for R2. R4 R4 was admitted on December 16, 2021, and had diagnoses including spastic quadriplegic cerebral palsy (a neuromuscular disorder) and type two diabetes (a long-term condition in which the body has trouble controlling blood sugar). R4's Individualized Service Plan Agreement dated December 16, 2021, indicated R4 received services including assistance with housekeeping, laundry, toileting, reassurance checks, transfers, and medication administration. R4's medical record included an initial comprehensive RN assessment, dated December 16, 2021, but lacked a subsequent nursing assessment within 14-days after start of services. On February 25, 2025, at 12:55 p.m., DO-C stated, via email, R4 admitted before they began managing the facility, and R4's record lacked a 14-day nursing assessment. The licensee's 6.01 Assessments, Reviews & Monitoring Resident policy dated September 5, 2024, indicated, "3. 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	01620		

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01620	Continued From page 17 needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for two of three residents (R2, 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: R2	01890		

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01890	Continued From page 18 R2's Service Plan - Waiver3 - MN, dated February 6, 2025, indicated R2 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, blood glucose testing, and medication administration. On February 24, 2025, at 10:53 a.m., the surveyor observed an un-named second-floor medication cart with unlicensed personnel (ULP)-E. The licensee had a total of three medication carts on the second floor located in the secured dementia care unit. The licensee's locked medication cart included one opened Lantus (long-acting insulin) pen for R2. R2's Lantus insulin pen lacked an opened date to indicate when it was first opened and used. ULP-E stated the caregivers were trained to label the insulin pens when brought to the med cart and opened. R2's medication administration record (MAR) dated, February 1, 2025, to February 24, 2025, indicated R2 received Lantus 30 units daily, at 8:00 p.m., as per R2's provider orders. R6 R6's Service Plan - Modification dated February 7, 2024, indicated R6 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, safety checks, blood glucose testing, and medication administration. On February 24, 2025, at 11:02 a.m., the surveyor observed a second un-named medication cart located in the secured dementia care unit with ULP-F. The locked medication cart included one opened Lantus pen for R6. R6's Lantus insulin pen lacked an opened date to	01890		

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01890	Continued From page 19 indicate when it was first opened and used. ULP-F stated the pen "should be dated," and showed the surveyor the typed manufacturer expiration date on the pen. R6's MAR dated, February 1, 2025, to February 25, 2025, indicated R6 received Lantus 10 units daily, at 8:00 a.m., as per R6's provider orders. The manufacturer's instructions for Lantus insulin pens revised June 2023, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. On February 24, 2025, at 11:15 a.m., director of operations (DO)-C stated the staff were trained to label and date multi-use insulin pens when opened. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated, "Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for	01910		

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01910	Continued From page 20 disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record, the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 had diagnoses including dementia with aggressive behavior and thrombocytopenia. A discharged resident roster provided by the licensee indicated R1 started receiving services	01910		

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01910	Continued From page 21 December 2, 2024, and was discharged January 24, 2025. R1's record included a resident note, dated January 24, 2025, at 1:06 p.m. The resident note indicated, "11am (sic)Transferred from [Licensee] this morning. Brought over by LALD. All personal possessions were moved over. Service Plan created. Medications were brought over by [Licensee] nurse and placed in medication cabinet." R1's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On February 25, 2025, at 10:33 a.m., registered nurse (RN)-D stated she was not able to find a copy of R1's service plan. RN-D provided R1's Discharge Care Plan dated January 2, 2025. R1's discharge care plan indicated R1 received services including medication administration. On February 25, 2025, at 10:36 a.m., RN-D stated R1's medication disposition documentation was missing from R1's medical record. RN-D verbalized she was not employed with the licensee at the time of R1's discharge and there was no evidence of the disposition of R1's medication including the required information. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated, "Unused Prescription Drugs: -Current unused medications managed by [Licensee] will be returned to the pharmacy for	01910		

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01910	Continued From page 22 credit or given to the resident or the resident's representative (upon request), when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. -Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *02/24/25*
Time: 13:20:40
Report: 8058251044

Food and Beverage Establishment Inspection Report

Location:
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN55110
Ramsey County, 62

Establishment Info:
ID #: 0039410
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517573800
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 previously issued on 09/26/22 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

REISSUED - FOR NEWLY HIRED KITCHEN MANAGER

Issued on: 09/26/22 *Comply By: 01/31/23*

The following orders were issued during this inspection.

2-100 Supervision

2-103.11C ***** Priority 2 *****

MN Rule 4626.0035C The person in charge must ensure that employees and other persons entering the food preparation, food storage and warewashing areas of the establishment comply with the rule.

DISCONTINUE ALLOWING STAFF NOT RELATED TO FOOD PREP/SERVICE INTO THE KITCHEN AREA

Comply By: 02/24/25

Surface and Equipment Sanitizers

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 13:20:40
Report: 8058251044
White Bear Lake White Pine

Food and Beverage Establishment Inspection Report

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

Process/Item: TOMATO
Temperature: 39 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR: DEDE HINNENDAEL

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 8058251044 of 02/24/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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