Electronically Delivered

October 31, 2022

Administrator
Whitefish At The Lakes Senior
35625 Ostlund Avenue
Cross Lake, MN 56442

RE: Project Number(s) SL35750015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 28, 2022, 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.

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 . . ."

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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that

consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

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,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35750	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

(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 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: SL35750015 On September 27, 2022, through September 28, 2022, 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 eighty-six (86) residents receiving services under the provider's Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all three residents in the Assisted Living 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) 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 September 28, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel ((ULP)-C) providing personal cares. This had the potential to affect all eighty-six (86) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client'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).	0 510		

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0 510	Continued From page 3 The findings include: On September 28, 2022, at 9:25 a.m., ULP-C wore gloves while distributing plates of food to residents during the breakfast service. ULP-C took plates with food items from the portable cabinet used to keep food warm and served residents sitting at the dining tables. During this time, ULP-C conversed with staff and residents. ULP-C walked into the kitchen while still wearing gloves that she had used to deliver meal plates and raised her hand to head and scratched her head. ULP-C did not remove her gloves or wash her hands after scratching her head and proceeded to take a plate of food from the portable cabinet and brought to residents sitting at the time. ULP-C then went into the kitchen, obtained a cart used for picking up dirty dishes and brought the cart into the dining area. ULP-C began to remove dirty plates from the tables where residents had been eating. While ULP-C was picking up a used plate from R4, ULP-C asked R4 if there was anything else she needed. R4 requested a banana. With the same gloved hands, ULP-C picked up the banana from the fruit bowl on the kitchen counter and gave to R4. ULP-C continued to pick up dirty plates and glasses from the tables and placed them into a container on the cart she had brought into the dining room. ULP-C removed her gloves as she walked out of the dining area, put them into a garbage container, and continued to walk down the hall of the memory care. ULP-C did not wash her hands after removing the gloves. During interview on September 28, 2022, at 11:30 a.m., surveyor explained to registered nurse (RN)-A and licensed assisting living director (LALD)-D what observations were seen with	0 510		

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0 510	Continued From page 4 ULP-C. LALD-D stated ULP-C would need to be re-educated. The licensee's Handwashing and Sanitizing policy, dated January 1, 2017, indicated hands must be washed thoroughly with antimicrobial soap and water, including but are not limited to before and after assisting residents or staff with any contact with bodily fluids, blood, mucous membranes, non-intact skin, or any other contaminated surfaces and before and after gloving. The licensee's Personal Protective Equipment policy, undated, indicated gloves are single-use items and should be used for invasive procedures including contact with sterile sites, non-intact skin, or mucous membranes, and for activities that have been assessed as carrying a risk of exposure to blood, body fluid or infectious respired aerosols or droplets. They must be put on immediately before an episode of client contact or treatment. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
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;	0 810		

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0 810	Continued From page 5 (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 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 document review and interview, the licensee failed to provide the required evacuation drill frequency. This had the potential to directly affect all residents 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	0 810		

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0 810	Continued From page 6 of the residents). The findings include: On September 28, 2022, at approximately 12:15 p.m., the director of environmental services (ES)-J provided documents for review. Documents were reviewed by survey staff on September 28, 2022, between 12:15 p.m. and 1:00 p.m. Completed evacuation drill logs dated 01-16-22, 02-10-22, 05-18-22, and 06-20-22 were provided. The licensee did not meet the evacuation drill frequency requirement of at least one drill every other month. On September 28, 2022, at approximately 12:45 p.m., the ES-J explained during an interview that another employee had been responsible for these evacuation drills and that moving forward they would ensure that the frequency requirements would be met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 7 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for one of one resident (R3) with record 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	01060		

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01060	Continued From page 8 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: The licensee's Resident Roster identified R3's date of admission was November 13, 2021, and date of emergency transfer to a local hospital for evaluation was July 9, 2022. R3 returned to licensee from the hospital on July 14, 2022. R3's nurse progress note dated July 9, 2022, indicated R3 was sent to the area local hospital for evaluation. Per nursing progress noted on July 14, 2022, R3 returned to licensee. During interview on September 27, 2022, at approximately 10:15 a.m., licensed assisted living director (LALD)-D and registered nurse (RN)-A stated they were not aware that the Regional Ombudsman needed to be notified when a resident was out of the establishment for more than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01620		

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01620	Continued From page 9 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment following a change of condition for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 10 The findings include: R3 was admitted for assisted living dementia care services on November 13, 2021, with diagnoses including but not limited to a history of breast cancer, Parkinson's disease, and generalized osteoarthritis. R3's nurse progress note dated July 19, 2022, at 1:17 a.m., indicated RN-J observed R3's buttocks area and noted R3 had "some open areas to coccyx and gluteal fold." No measurements of open skin areas were obtained. R3's nurse progress note dated July 24, 2022, at 5:15 p.m., indicated licensed practical nurse (LPN)-G had been notified by an unlicensed personnel (ULP) that R3 had two open areas in R3's gluteal cleft near R3's coccyx. Measurements of open areas (right cleft: 1.5 centimeter (cm) by 1.0cm) (left cleft: 0.5cm by 0.5cm) were obtained by LPN-G. R3's nurse progress note dated July 25, 2022, indicated RN-H observed R3's buttocks and gluteal cleft. Progress note indicated three open areas were observed and were described as "dime, pea, and pencil tip open areas." No measurements of open skin areas were obtained. R3's nurse progress note dated August 3, 2022, indicated LPN-G had observed R3's buttocks and noted, "two superficial non-infected wounds, about the size of a pencil eraser." No measurements of open skin areas were obtained. R3's nurse progress note dated August 10, 2022, indicated LPN-I observed R3's buttocks and noted "it is clearing up with minimal redness." No measurements of open skin areas were obtained.	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

(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
01620	Continued From page 11 There was no indication an RN had been notified of LPN-I's skin observation. R3's nurse progress note dated August 26, 2022, indicated staff had notified LPN-I of two reddened areas on R3's coccyx. LPN-I indicated the two reddened areas were not open skin areas. There was no indication an RN had been notified of LPN-I's skin observation. During an interview on September 28, 2022, at 10:40 a.m., R3's daughter indicated R3 had open areas on the buttocks area. R3's daughter stated there had been a camera installed in R3's room and there had been no skin assessments completed by an RN since July 2022. During an interview on September 28, 2022, at 11:10 a.m., RN-A verified there had been no open skin area measurements taken since July 24, 2022, and no RN assessments completed since July 25, 2022. The licensee's Comprehensive Assessment Schedule dated August 2022, indicated changes in client condition would be assessed by an RN. The assessments schedule also indicated alteration in skin integrity assessments would be completed in person weekly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	01650		

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	35750	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 12 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included all the required content for one of one resident (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	01650		

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	35750	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 13 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 had an admission date of April 14, 2022. R2's service plan dated April 14, 2022, lacked indication of whom the responsible person would be in case of an emergency or if there was a significant adverse change of condition for R2. R2's service plan also lacked indication of who the responsible party would be to sign for R2 in case of an emergency. On September 28, 2022, at approximately 10:55 a.m., registered nurse (RN)-A verified the service plan for R2 lacked the information indicated. RN-A indicated she was not aware this information was not included in R2's service plan. The licensee's Service Plan policy, dated April 2022, indicated the service plan will include names and contact information of persons the client wishes to have notified in an emergency including identification of who will sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

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	35750	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

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02040	Continued From page 14 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents 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 September 28, 2022, at approximately 12:15 p.m., the director of environmental services (ES)-J provided documents for review. Documents were reviewed by survey staff on September 28, 2022, between 12:15 p.m. and 1:00 p.m. The hazard and vulnerability assessment tool did not include hazards or safety risks identified on and around the property. The assessment did not include the mitigation of property hazards to protect residents from harm.	02040		

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	35750	A. BUILDING: _____ B. WING _____	09/28/2022

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WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

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02040	Continued From page 15 On September 28, 2022, at approximately 1:00 p.m., the licensed assisted living director (LALD)-D confirmed during an interview that the licensee had not included safety risks or hazards on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35750	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

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02410	Continued From page 16 assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for one of one resident (R6) observed during medication administration. 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 September 27, 2022, at approximately 3:08 p.m., R6 was seated in the common dining area doing an art activity with other residents, an activity personnel, and one resident's visitor. Unlicensed personnel (ULP)-E approached R6 carrying a medication cup and a small glass of water. ULP-E bent down next to R6 and announced what medications R6 would be taking. ULP-E explained to R6 that she needed to take the medications. During this time, the other residents sitting at the table with R6 stopped the activity they were doing and drew their attention to ULP-E and R6. On September 28, 2022, at approximately 11:47 a.m. licensed assisted living director (LALD)-D, stated it was never okay to administer medications in a common area. LALD-D stated all medication administration needed to be	02410		

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WHITEFISH AT THE LAKES SENIOR	**35625 OSTLUND AVENUE CROSS LAKE, MN 56442**

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02410	Continued From page 17 conducted in the privacy of the resident's room. LALD-D stated all employees administering medications have been instructed of this and ULP-E would need to receive additional education. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *09/28/22*
Time: 13:30:00
Report: 1017221197

Food and Beverage Establishment Inspection Report

Location:
Whitefish at the Lakes Senior
35625 Ostlund Avenue
Crosslake, MN56442
Crow Wing County, 18

Establishment Info:
ID #: 0036201
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Whitefish Senior Living, LLC

Phone #: 2182100770
ID #: 53355

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

The following orders were issued during this inspection.

3-400A Destroying Organisims: cooking time/temperature, freezing

3-401.11A1A ** Priority 1 **

MN Rule 4626.0340A Cook raw eggs that are broken and prepared in response to the consumer's order and for immediate service to 145 degrees F (63 degrees C) or above for 15 seconds.

RAW SHELL EGGS ARE BEING COOKED OVER EASY FOR IMMUNOCOMPROMISED CLIENTS. COOK EGGS TO 145 DEGREES F.

Comply By: 09/28/22

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.

THERMOMETER FOR DISH MACHINE WAS NOT WORKING DURING INSPECTION, REPLACE BATTERIES.

Comply By: 09/28/22

Surface and Equipment Sanitizers

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: QUAT DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: MILK LOCATED IN UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 132 Degrees Fahrenheit - Location: SALSBERRY STEAK LOCATED IN CAMBRO MEMORY CARE UNIT
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK LOCATED IN UNDER COUNTER COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: ORANGE JUICE LOCATED IN DISPENSER MEMORY CARE UNIT
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: FRUIT MEDLY LOCATED IN UPRIGHT BY MEMORY CARE UNIT
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: CUSTARD LOCATED IN WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: AMERICAN CHEESE LOCATED IN PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLICED TOMATOES LOCATED IN PREP TOP
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLAW LOCATED UNDER PREP COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 201 Degrees Fahrenheit - Location: STEAK LOCATED IN WARMER ON SERVING LINE

Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

COOK TEMPS OF EGGS AND MEATS.

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 Minnesota Department of Health inspection report number 1017221197 of 09/28/22.

Certified Food Protection Manager: KATHERINE A THOMAS

Certification Number: FM 10320 Expires: 02/01/23

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Establishment Representative

INSPECTOR ID # 1017

651-201-4500
health.foodlodging@state.mn.us

Report #: 1017221197

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	09/28/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	13:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Whitefish at the Lakes Senior	**Address** 35625 Ostlund Avenue	**City/State** Crosslake, MN	**Zip Code** 56442	**Telephone** 2182100770
License/Permit # 0036201	**Permit Holder** Whitefish Senior Living, LLC	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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		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		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		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		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:** 09/30/22

Inspector (Signature)