DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 24, 2023

Licensee
The Waters Of White Bear Lake
3820 Hoffman Road
White Bear Lake, MN 55110

RE: Project Number(s) SL32917015

Dear Licensee:

On April 19, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Electronically Delivered

March 23, 2023

Licensee
The Waters Of White Bear Lake
3820 Hoffman Road
White Bear Lake, MN 55110

RE: Project Number(s) SL32917015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $6,500.00. You will be invoiced approximately 30 days after 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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. 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 Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
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: SL32917015 On February 21, through February 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 123 active residents; 46 receiving services under the Assisted Living with Dementia Care license. On February 21, 2022, the immediacy of correction order 0470 has been removed, however non-compliance remains at a scope and level of I. On February 23, 2022, the immediacy of correction order 2070 has been removed, however non-compliance remains at a scope and level of I.	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.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 2	0 470		

not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 21, 2023, at 10:00 a.m., during the entrance conference, license assisted living director (LALD)-C stated the licensee's facility included two secured units which required the use of a key fob to enter and exit. The two secured memory care units were on two different floors of the facility, 1st and 2nd floor. LALD-C stated the overnight shift was from 11:00 p.m. until 7:30 a.m. and had three staff working the overnight shift.

R2's comprehensive nursing assessment dated February 10, 2023, indicated R2 required "physical assist of 2 for transfers: Mechanical lift with transfers." R2 resided in the assisted living portion of the building just outside of the 2nd floor memory care unit in room 218.

On February 21, 2023, at 12:00 p.m., R2 was observed being transferred in his apartment, in room 218, with a Hoyer lift by two unlicensed personnel (ULPs) from his recliner into his bed by ULP-B and ULP-F.

On February 21, 2023, at 11:45 a.m., LALD-C stated there were residents who were not on the memory care unit who required two-person transfers with the use of a Hoyer lift. LALD-C stated the resident rooms for those requiring a

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0 470	Continued From page 3 two-person transfer were just outside of the 2nd floor memory care unit. On February 21, 2023, at 1:37 p.m., regional registered nurse (RRN)-E stated they had three staff members on the overnight shift with one staff on each memory care unit and one staff to cover the rest of the assisted living residents in the facility. Surveyor asked how they would address a two-person transfer, R2 for example, on the overnight shift for someone who was not on the memory care unit. RRN-E stated they should not be doing so as it would mean leaving the memory care unit unattended. Director of nursing (DON)-D agreed with RNN-E the overnight staffing would not allow for a transfer to occur off the memory care units without one of the two memory care floors being left unattended. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated July 31, 2021, indicated: "- From the hours of 10:00pm to 6:00am [LALD-C stated during the entrance conference the overnight shift was from 11:00 p.m. to 7:30 a.m.], direct-care staff will respond to a resident request for assistance with health or safety needs within a reasonable amount of time. - A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two. - One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be: i. Awake ii. Located In: 1. The same building -OR-	0 470		

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0 470	Continued From page 4 2. An attached building-OR- 3. On a contiguous campus within the facility in order to respond within a reasonable amount of time iii. Capable of communicating with residents iv. Capable of summoning appropriate assistance v. Capable of following directions - The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and will be adequate to address: a. Each resident's needs as identified in the service plan and assisted living contract b. Each resident's acuity level as determined by the most recent assessment or Individualized review c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises d. The staffing plan will Indicate If the assisted living has a secured dementia care unit e. Staff competency and training." The licensee's Staffing Plan dated August 2, 2022, indicated the overnight shift would be staffed with two unlicensed personnel and one licensed practical nurse (LPN). The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDULSA) dated November 20, 2022, indicated the licensee provided, "Mechanical lift: assist of 2 transfer" services. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		

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0 470	Continued From page 5 On February 21, 2022, the immediacy of correction order 0470 has been removed as confirmed by review by evaluation supervisor, however non-compliance remains at a scope and level of I.	0 470		
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 establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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, 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	0 510		

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0 510	Continued From page 6 has affected or has the potential to affect a large portion or all of the residents). The findings include: SHARPS CONTAINER On February 22, 2023, at 8:46 a.m., a red sharps container (a red colored puncture resistant and spill proof container in which used needles or other sharp objects with bodily fluids are to be stored safely), approximately 12x4x14 inches (in.) in size, was noted to be stored on the top of the refrigerator in resident (R)4's room. The container was noted to be about half full of lancets (device commonly used to pierce a person's skin to create a blood drop to test blood sugar) and needles that had been used with an insulin administration pen. The container lacked the required safety lid designed to prevent a person from easily accessing the used items and/or spilling any liquid biohazard contents. Unlicensed personnel (ULP)-I was observed administering insulin to R4 then reached up on top of the refrigerator to drop a lancet and needle from the insulin administration pen into the red sharps container. On February 22, 2023, at 8:46 a.m., ULP-I stated the red sharps container should have a lid to prevent residents and staff from reaching in and harming themselves. On February 22, 2023, at 9:09 a.m., registered nurse (RN)-A stated sharps containers should always have a lid for safety. RN-A stated a sharps container should be removed immediately if there is a missing or broken lid to prevent harm to staff and residents. HAND HYGIENE	0 510		

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0 510	Continued From page 7 On February 21, 2023, at approximately 12:00 p.m., observed ULP-E provide cares including transfer and changing R2's brief. ULP-E donned (put on) and doffed (took off) their gloves without performing hand hygiene before and after. On February 22, 2023, at approximately 7:00 a.m., observed ULP-B provide medication administration to R3 including application of a skin lotion. ULP-B donned and doffed their gloves without performing hand hygiene before and after. On February 22, 2023, at 7:26 a.m., observed ULP-H provide toileting assistance to R5 which included peri cares after urination. R5 was observed contributing to her own toileting cares. ULP-H doffed gloves without performing hand hygiene after for herself and R5. ULP-H then grabbed a brush from the bathroom drawer and began to brush R5's hair. ULP-H was observed walking R5 down to the dining area for breakfast. On February 22, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C stated the licensee's expectations are sharps container are to be sealed with the appropriate lid and stored in a secured area only accessible by staff. LALD-C indicated the sharps container should never be stored in a memory care resident's room due to safety of the resident. Additionally, RN-E stated the expectation for all employees is to complete hand hygiene before and after when gloves are donned or doffed. The licensee's Hand Hygiene Policy and Procedure policy dated February 4, 2020, indicated the licensee's staff members, "must wash their hands with soap and water before and after performing resident care and before and	0 510		

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0 510	Continued From page 8 after donning gloves during a procedure." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on the interview and record review, the	0 680		

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0 680	Continued From page 9 licensee failed to perform the monthly load test runs and weekly inspections of the emergency power generator to meet the requirements outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. This had the potential to affect all residents and staff in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On February 22, 2023, at approximately 3:00 p.m., document review and interview with the licensed assisted living director (LALD)-C and the director of maintenance (DM)-J, survey staff requested records relating to the emergency generator inspections, maintenance, and load test runs for review. The only record received for review was for the annual inspection/preventive maintenance performed by a contractor dated January 3, 2022. No other required generator records were available or provided for review. On February 22, 2023, at approximately 3:00 p.m., a record review indicated the licensee failed to meet the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as outlined under	0 680		

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0 680	Continued From page 10 NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: -Required weekly inspections of the generator system. -Required monthly generator load tests. -Required monthly transfer switch operation tests. On February 22, 2023, at approximately 3:15 p.m., during the exit interview, the DM-J and the LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents,	0 800		

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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0 800	Continued From page 11 visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 22, 2023, approximately from 10:40 a.m. to 2:30 p.m., survey staff toured the facility with the director of maintenance (DM)-J. On February 22, 2023, at approximately 3:00 p.m., the licensee lacked a record of the annual fire alarm detection tests and inspections to ensure the proper performance of the building fire alarm system. This finding was evident during document review and interview at 3:00 p.m. with the licensed assisted living director (LALD)-C and the DM-J when survey staff requested documentation relating to the annual inspection and testing of the fire alarm and detection system test and no record or documentation was provided or available for review. An email was received from the DM-J on Friday 02/23/2023 at 2:46 p.m. indicating that the contractor was searching for the fire alarm test record, but no record of test and inspection was provided for further consideration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 12	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 810		

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0 810	Continued From page 13 interview, the licensee failed to provide complete content of the fire safety and evacuation plan, required training, and the minimum required employee evacuation drills. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 22, 2023, approximately from 10:40 a.m. to 2:30 p.m., with the director of maintenance (DM-J), survey staff observed the posted evacuation floor plan layout throughout the facility lacked location and numbers of sleeping rooms. The DM-J verified the finding. On February 23, 2023, at approximately 3:00 p.m., survey staff reviewed the facility fire safety and evacuation plan and related documentation received from the licensed assisted living director (LALD)-C and the DM-J. At approximately 3:15 p.m., document review and interview with the LALD-C and the DM-J indicated the following: TRAINING -The documentation review showed incomplete employee training on the facility-specific fire safety and evacuation plan at least twice per year (after new orientation). Record and review consisted of a staff log of emergency/disaster	0 810		

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0 810	Continued From page 14 training (In-Service Training Log), dated 6/23/2022, Relias transcripts for online training, and emergency training information/slides (no date noted). -The record review indicated the lack of resident training record for residents who are capable of assisting in their own evacuation on proper actions to take during a fire event including movement, evacuation, or relocation. The training must be available to residents at least once a year. Documentation (and pdf slides) review indicated the documentation did not include a date to verify compliance for this requirement. FIRE and EVACUATION DRILLS The record and documentation review indicated the licensee failed to meet the minimum required employee fire and evacuation drills. Fire drill records received for review were dated 11/18/2022 (no time specified) and 11/3/2021 (a.m. shift). Survey staff explained to the LALD-C and the DM-J that drills must also include evacuation drills and be performed at least twice per year per shift, with at least one evacuation drill every other month. Fire drills and evacuation drills may be combined when conducting drills. On February 22, 2023, at approximately 3:30 p.m., during the exit interview, the LALD-C and the DM-J acknowledged the above findings. Additional information was provided by the LALD-C on Wednesday, 02/22/2023, at 4:26 PM, with a pdf attachment of Appendix G, resident guide/handbook (7-20-21), resident training, staff log of emergency/disaster training (6/23/2022), Relias transcripts, and emergency training information (no date noted).	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for one of two employees (registered nurse (RN)-A). 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	01540		

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01540	Continued From page 16 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-A was hired on December 12, 2022, and provided supervisory and direct care services to residents of the facility. RN-A's undated Relias (an online training platform) transcript included 6.25 hours of dementia training. RN-A's employee record lacked documentation of the required 8 hours of dementia care training to be completed within 80 hours of employment start date. On February 21, 2023, at 3:14 p.m., regional registered nurse (RRN)-E stated dementia training was all completed on Relias. RRN-E stated she believed there was enough dementia care training for RN-A. When shown RN-A's Relias transcript RRN-E acknowledged RN-A was short of the required 8 hours dementia care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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01640	Continued From page 17 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident or resident's representative to document agreement of services to be provided for one of four 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).	01640		

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01640	Continued From page 18 The findings include: R2 was admitted on August 3, 2022. R2's untitled six-page document with effective date of August 10, 2022, identified by licensed assisted living director (LALD)-C as R2's current service plan, indicated R2 required, "Transfer Assist of 1," service. R2's Progress Notes dated January 10, 2023, at 3:11 p.m., read, "Services updated to include transfer assist of 2 with mechanical lift." R2's Health and Wellbeing Assessment dated February 10, 2023, read under Section 2. Functional Capabilities, "6. Indicate level of assistance needed for transfers: F. Needs/receives physical assist of 2 for transfers: Mechanical lift with transfers." On February 21, 2023, at approximately 12:00 p.m., observed unlicensed personnel (ULP)-B and ULP-F provide R2 a transfer with two (2) persons with a Hoyer (a mechanical full body lift utilizing a sling) from R2's recliner to R2's bed. ULP-B indicated R2 had required a 2-person assisted transfer with the Hoyer since R2 had returned from a transitional care unit post amputation below the knee on R2's left leg. R2's unsigned identified service plan with effective date of February 21, 2023, at 1:58 p.m., indicated R2 required, "Transfer Assist of 2," service. On February 22, 2023, at 12:00 p.m., LALD-C indicated the licensee's expectations are service plans for all residents would have been current and contain authentication of the licensee and	01640		

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01640	Continued From page 19 resident or resident's representative. LALD-C stated R2 had a change in condition and assessments were completed but the service plan was not updated to reflect R2's current needs. The licensee's Resident Service Plans policy dated July 13, 2021, indicated resident service plans be reviewed and singed by the resident to agree to services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document administered medications per provider orders for one of three	01760		

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01760	Continued From page 20 residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's service plan dated December 12, 2022, indicated R4 received medication management services. R4's medication administration record (MAR) dated February 2023, indicated to give Humalog Kwikpen 100unit (u)/milliliter (ml) pen insulin units for the following blood glucose (BG) results: - 140-189 =1u; - 190-239=2u; - 240-289=3u; - 290-339=4u; - 340-399=5u; - 400-449=10u; - 450-500=12; - BG greater than 500=15u. R4's MAR lacked documentation of the quantity of insulin administered for the following dates and times: -February 3-8, 2023; at 8:00 a.m.; -February 5-7, 2023, at 12:00 p.m.; and -February 1, 2, 4, 6 and 7, 2023, at 5 p.m. On February 22, 2023, at 10:53 a.m., director of nursing (DON)-D stated a MAR should never have blank spaces on it. DON-D stated the quantity of insulin administered to R4 should have	01760		

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01760	Continued From page 21 been documented. The licensee's Administration of Medication policy dated September 13, 2021, indicated, "Document medication administration on the EMAR after administration." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel,	01790		

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01790	Continued From page 22 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) documented training and competencies for unlicensed personnel ((ULP)-B)	01790		

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01790	Continued From page 23 who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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: On February 22, 2023, at approximately 7:00 a.m., ULP-B provided medications to R2 and R3 including oral pills, eye drops, transdermal patch, and topical lotion. ULP-B was hired on May 19, 2014, and began providing services under the licensee's assisted living with dementia care license on August 1, 2021. ULP-B's training record lacked documentation ULP-B was trained and found competent to provide medications to residents who had unplanned times away. On February 22, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C indicated the licensee provided training for unplanned time away to all ULPs who provided medication administration but was unable to locate the documentation for ULP-B. LALD-C indicated ULP-B had worked at licensee's other locations prior to transferring to the current location and training documentation was most likely lost during the transfers.	01790		

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THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01790	Continued From page 24 The licensee's Medication Administration - Outings and Unplanned Leaves of Absence policy dated May 26, 2017, indicated ULPs would be delegated the task for sending medications with a resident who had unplanned time away. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of four residents (R7) with medication management services. 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:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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01880	Continued From page 25 R7 was admitted to services on November 24, 2020. R7's Personal Care Options with effective date February 27, 2023, identified by licensed assisted living director (LALD)-C as R7's current service plan, indicated R7 received medication management services. R7's Health and Wellbeing Assessment dated January 27, 2023, read under Section 6. Medication Management, "6. Medications will be: B. Stored in the client unit. 6.b.1. Located: medication is locked up in a locked box in the resident's apartment. 6.b2. Secure? Yes. 6.b3. Secure medications can be accessed by: A. Licensed staff." On February 22, 2023, at approximately 7:00 a.m., observed unlicensed personnel (ULP)-B provide oral medication administration to R7 in R7's room. On R7's kitchen counter was an opened box of albuterol (a common nebulizer medication stored in individual plastic vials). Additionally, R7's refrigerator contained two (2) boxes of Humalog insulin pens (insulin in pen like device used to administer insulin to a person), one box appeared opened, and the other box appeared to be sealed new. On February 22. 2023, at approximately 7:00 a.m., ULP-B stated they were unsure if insulin would be stored in the resident's refrigerator as ULP-B does not administer insulin to R7. ULP-B stated a registered nurse (RN) would be able to identify if insulin would be stored in each resident's room who required insulin. On February 22, 2023, at approximately 9:30 a.m., although RN-A stated all medications for	01880		

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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01880	Continued From page 26 residents who resided in licensee's secured memory care unit would have all medications locked and stored in the nursing office refrigerator, RN-A stated they were unsure of the storage of insulin for residents who resided in the non-secured assisted living areas of the facility but would ask the director of nursing (DON)-D. DON-D stated all mediations including insulin should be securely stored and medications requiring refrigeration would be secured in the nursing office refrigerator and not in resident's room who licensee provided medication management services. The licensee's Medication Administration - Medication Storage policy dated September 5, 2019, indicated all medications would be securely stored and medications which require refrigeration would be stored in the Health and Wellbeing team office refrigerator. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01890		

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01890	Continued From page 27	01890		

review, the licensee failed to ensure medications included labeling with an opened-on date for one of four residents (R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R4's service plan dated December 12, 2022, indicated R4 received medication management services and had a diagnosis of type 1 diabetes mellitus.

R4's medication administration record (MAR) dated February 2023, indicated R4 took Lispro Kwikpen insulin (Humalog 100unit (u)/milliliter (ml) pen); administer three (3) times per day for the following blood glucose (BG) results:
- 140-189=1u;
- 190-239=2u;
- 240-289=3u;
- 290-339=4u;
- 340-399=5u;
- 400-449=10u;
- 450-500=12; and
- BG greater than 500=15u.

On February 22, 2023, at 8:46 a.m., unlicensed personnel (ULP)-I was observed preparing and administering R4's Lispro Kwikpen insulin which was not labeled with an opened-on date. The Lispro Kwikpen insulin (Humalog 100u/ml pen) had an expiration date of February 28, 2025, and

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01890	Continued From page 28 a LOT number of D484040C. On February 22, 2023, at 8:46 a.m., ULP-I stated insulin pens were supposed to be marked with an opened-on date. ULP-I acknowledged the Lispro Kwikpen insulin was not labeled with an opened-on date. On February 22, 2023, at 9:09 a.m., registered nurse (RN)-A stated insulin should always be labeled with an opened-on date. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01940	Continued From page 29 problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident and documented those instructions in the resident's record for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4's medication and treatment administration record (MAR/TAR) dated February 2023, indicated R4 received assistance with blood glucose (BG) monitoring four times per day. R4's MAR/TAR for February 2023, indicated on five different occasion R4's glucometer (device for measuring BG levels) gave a reading of "High"	01940		

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01940	Continued From page 30 which would indicate R4's BG level was too high for the glucometer to read. R4's record lacked specific instruction of when to notify R4's nurse or provider for elevated BG levels. On February 22, 2023, at 11:10 a.m., director of nursing (DON)-D stated the glucometer would indicate "High" rather than a number if the BG was too high for the glucometer to read. DON-D stated she wasn't sure if R4's record had parameters for BG readings but there may have been some in the service plan. DON-D stated it was expected nursing would be notified of "High" readings. On February 22, 2023, at 11:20 a.m., registered nurse (RN)-A stated they were unable to locate any specific parameters of when to notify the nurse or provider on R4's service plan for elevated BG readings. RN-A stated they searched R4's record and could not find documentation a nurse or provider was notified of the elevated BG readings. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01960	Continued From page 31	01960		

include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee's unlicensed personnel (ULP) failed to notify nursing when treatment results fell outside of written parameters for one of four residents (R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R4's medication and treatment administration record (MAR/TAR) dated February 2023, indicated R4 received assistance with blood glucose (BG) monitoring four times per day. R4's MAR/TAR indicated, "Report blood glucose numbers to nursing if [below] 70."

R4's MAR/TAR for February 2023, indicated on nine (9) different occasions, R4's glucometer (device for measuring BG levels) gave a reading below 70 which indicated the ULPs should have notified nursing.

On February 22, 2023, at 11:10 a.m., director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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01960	Continued From page 32 nursing (DON)-D stated it was expected nursing would be notified for BG readings below 70 for any resident. DON-D stated they will look for documentation of R4's low BG readings being reported to nursing or a provider. On February 22, 2023, at 11:20 a.m., registered nurse (RN)-A stated they searched R4's record and could not find documentation of a nurse or a provider being notified of the BG readings below 70. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that 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 observation, document review, and interview, the licensee failed to perform mitigations for the assessed hazards and vulnerabilities on the safety hazard assessment	02040		

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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02040	Continued From page 33 plan on and around the property to protect the memory care residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. 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 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 clients). The findings include: An interview and document review were conducted on February 22, 2023, at approximately 3:30 p.m., with the licensed assisted living director (LALD)-C and the director of maintenance (DM)-J, on the safety risk assessment and mitigations for the physical environment of the facility to protect the memory care residents from harm. The review and interview indicated no plan was available for review. The LALD-C and the DM-J confirmed the finding and staff agreed to honor additional documentation for further consideration by end of next day (2/23/2023). Additional information was provided by the LALD-C on Wednesday, 02/22/2023, 4:26 PM, with a pdf attachment, Hazard vulnerability assessment for property/grounds, dated March 2022. Document review indicated the safety risk assessment plan lacked mitigation documentation to the safety risk and hazard vulnerabilities identified on the plan to protect all memory care residents from harm. The finding	02040		

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	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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02040	Continued From page 34 was evident as the column labeled " ...Mitigation" was not filled out. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests of residents for assistance in the secured dementia care (memory care) unit. This resulted in an immediate correction order issued on February 22, 2023. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
02070	Continued From page 35 The findings include: On February 22, 2023, at 7:05 a.m., the surveyor entered the 1st floor memory care unit and unlicensed personnel (ULP)-G was observed in the memory care unit dining area. ULP-G stated she was the overnight ULP and was just waiting to give report to the oncoming morning staff. On February 22, 2023, at 7:07 a.m., ULP-G was observed preparing to leave the 1st floor memory care unit and stated she was going to find the oncoming staff for the morning shift so she could give her change-of-shift report. ULP-G stated it was okay to leave the unit unattended because she would only be gone for a short period of time. On February 22, 2023, at 7:14 a.m., ULP-G was observed returning to the 1st floor memory care unit with the two dayshift ULPs, ULP-H and ULP-I. On February 22, 2023, at 8:02 a.m., ULP-H and ULP-I both stated they did the morning report in the nurse's office. Both stated the overnight ULP routine would be to leave the unit and go to the nurse's office to give their report. On February 22, 2023, at 9:05 a.m., observed both 1st floor memory care unit ULPs, ULP-H and ULP-I, at the nurse's station. Surveyor asked both ULP-H and ULP-I if anyone was on the 1st floor memory care unit and both ULP-H and ULP-I stated no one was (currently) on the 1st floor memory care unit. On February 22, 2023, at 9:09 a.m., registered nurse (RN)-A was present at the time both ULP-H and ULP-I were at the nursing station together at	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
02070	Continued From page 36 9:05 a.m. RN-A stated at least one staff member was required to be on the memory care unit at all times and both ULP-H and ULP-I should not have left the 1st floor memory care unit unattended. RN-A stated when ULPs were giving change-of-shift reports to one another it was to be done on the unit. Surveyor explained ULP-G was observed leaving the 1sf floor memory care unit unattended from 7:07 a.m. to 7:14 a.m. to give her change-of-shift report to the oncoming staff at the nurse's station. RN-A stated ULPs should do their change-of-shift report on the memory care unit and should never be left unattended. On February 22, 2023, at 11:35 a.m., regional registered nurse (RRN)-E and licensed assisted living director (LALD)-C both stated the expectation was staff do their change-of-shift report on the memory care units and not at the nurse's station, as it would leave the memory care units unattended. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated July 31, 2021, indicated: "- From the hours of 10:00pm to 6:00am [LALD-C stated during the entrance conference the overnight shift was from 11:00 p.m. to 7:30 a.m.], direct-care staff will respond to a resident request for assistance with health or safety needs within a reasonable amount of time. - A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two. - One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be:	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

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02070	Continued From page 37 i. Awake ii. Located In: 1. The same building -OR- 2. An attached building-OR- 3. On a contiguous campus within the facility in order to respond within a reasonable amount of time iii. Capable of communicating with residents iv. Capable of summoning appropriate assistance v. Capable of following directions - The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and will be adequate to address: a. Each resident's needs as identified in the service plan and assisted living contract b. Each resident's acuity level as determined by the most recent assessment or Individualized review c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises d. The staffing plan will Indicate If the assisted living has a secured dementia care unit e. Staff competency and training." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On February 23, 2022, the immediacy of correction order 2070 has been removed as confirmed by review by evaluation supervisor, however non-compliance remains at a scope and level of I.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
02110	Continued From page 38	02110		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
02110	Continued From page 39 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care required policies and procedures were provided to four of four residents (R2, R3, R4, R5). 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 of the residents). The findings include: R2 was admitted on August 3, 2022. R2's record lacked documentation the licensee provided the required policies and procedures at the time of move-in. R3 was admitted on May 6, 2021. R3's record lacked documentation the licensee provided the required policies and procedures at the time of move-in. R4 was admitted on December 12, 2022. R4's record lacked documentation the licensee provided the required policies and procedures at the time of move-in. R5 was admitted on September 12, 2022. R5's record lacked documentation the licensee	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	02/23/2023

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THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN 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
02110	Continued From page 40 provided the required policies and procedures at the time of move-in. On February 22, 2023, at approximately 11:35 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-E indicated the licensee had developed the required policies and procedures, but the licensee had failed to obtain evidence R2, R3, R4, and R5 received the policies as required. RN-E stated the policies were available for review at the front desk for all to request and review, but no documentation would be in any resident record that the residents or residents' representative were provided the required policies and procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *02/21/23*
Time: 13:04:11
Report: 8058231044

Food and Beverage Establishment Inspection Report

Location:
The Waters Of White Bear Lake
3820 Hoffman Road
White Bear Lake, MN55110
Ramsey County, 62

Establishment Info:
ID #: 0038043
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513136440
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

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

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

Food and Equipment Temperatures

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

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

Process/Item: TOMATO
Temperature: 38 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: SOUP
Temperature: 140 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Process/Item: PREP
Temperature: 41 Degrees Fahrenheit - Location: TOMATO
Violation Issued: No

Type: Full
Date: *02/21/23*
Time: 13:04:11
Report: 8058231044
The Waters Of White Bear Lake

Food and Beverage Establishment Inspection Report

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

COMMERCIAL SPACE

HRD INSPECTOR BRANDON MUELLER

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 8058231044 of 02/21/23.

Certified Food Protection Manager: NANCY RAMSEY

Certification Number: 79919 Expires: 09/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us