Electronically Delivered

March 27, 2023

Licensee
The Waters On 50th
3500 50th Street West
Minneapolis, MN 55410

RE: Project Number(s) SL30282015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,

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
	30282	A. BUILDING: _____ B. WING _____	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS ON 50TH	3500 50TH STREET WEST MINNEAPOLIS, MN 55410

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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: SL30282015 On February 27, through February 28, 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 86 active residents; 59 receiving services under the Assisted Living with 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630		

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0 630	Continued From page 2 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of five residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 28, 2023, at approximately 1:00 p.m., observed R6's room with two (2) sharp knives and one (1) scissors unsecured and located on top of R6's refrigerator. One knife had a 4-inch blade and the other had a serrated 3-inch blade. The scissors appeared to have a 4-inch cutting blade and commonly used as a kitchen scissors. R6's door to their room was open to the common area and other residents were moving about the common area without staff in direct line of sight to observe if any	0 630		

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0 630	Continued From page 3 resident would enter R6's room. R6 was admitted October 7, 2021, and resided in licensee's secured memory care unit. R6's diagnosis included type 2 diabetes, hypertension (high blood pressure), altered mental statues, and encephalopathy (damage or disease that affects the brain's function or structure resulting in a person being confused or not acting as they usually do). R6's Physician Order Sheet dated February 1, 2023, read, "2/08/22 - Quetiapine 25mg tablet (Seroquel 25 mg tab) - take 1 tab by mouth twice aday [sic] as needed for agitationat [sic] least 4 hours apart. - PRN Indicated for agitationat [sic] least 4 hours apart." (Quetiapine is a provider ordered antipsychotic medication used to help calm a person when agitated or showing indications of agitation.) R6's Health and Wellbeing Assessment dated February 13, 2023, read under Fall Risk Evaluation, "8. Increased Anxiety/Emotional Liability B. Yes (5 pts): Frequent agitation and aggressive behaviors." R6's medication administration record (MAR) dated February 2023, included documentation R6 received quetiapine 25 mg tablet as needed medication on February 13, 2023. R6's Progress Notes dated February 15, 2023, at 3:56 p.m. read, "The last few days, [R6] has been more agitated, having increase in yelling, thinking that [R6] is hosting a seminar and no was listening. [R6] has been yelling out at others." R6's Service Agreement dated February 22,	0 630		

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0 630	Continued From page 4 2023, at 11:00 a.m., indicated R6 required Behavior Monitoring twice a day beginning on March 15, 2022, but did not indicate what specifically was being monitored or the interventions when the target behaviors would arise. R6's Vulnerability Assessment/Abuse Prevention Plan dated February 27, 2023, indicated R6 was not at risk to abuse others or had aggressive behavior. On February 28, 2023, at approximately 1:30 p.m., director of nursing (DON)-D stated R6 should not have access to sharp knives and scissors. DON-D stated the items would be removed immediately and R6's abuse prevention plan should address R6's ability to use and have access to any item that may cause harm or used to harm others. The licensee's Individual Resident Abuse Prevention Plans policy dated May 26, 2017, indicated resident abuse prevention plans would include assessment of environmental factors and include interventions by the licensee to minimize the risk of abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 5 (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 interview and record review, the licensee failed to show fire protection procedures necessary for residents, and procedures for movement, evacuation, or relocation including identification of unique or unusual resident needs; failed to provide required employee training on fire safety and evacuation. This had the potential	0 810		

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0 810	Continued From page 6 to affect all staff, residents, 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 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). Findings include: A record review and interview were conducted on February 28, 2023, at approximately 10:00 a.m. with the Executive Director (LALD)-C and Environmental Services Director (EM)-H on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. A record review of the emergency operations plan indicated that the plan did not have provisions for fire protection procedures necessary for residents or 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. During the interview, LALD-C stated she was not aware of any provisions 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. Record review of the fire safety and evacuation training indicated that employees did not receive training twice per year after initial hire. A policy provided by LALD-C stated that the licensee	0 810		

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0 810	Continued From page 7 provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. 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 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 8 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notice to the Office of Ombudsman for Long-Term Care (OOLTC) when the emergency relocation was greater than four (4) days for one of one resident (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, 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: R4 was admitted on November 24, 2014.	01060		

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01060	Continued From page 9 R4's Progress Notes dated November 17, 2022, at 1:10 p.m., indicated note was a late entry from an event R4 experienced on November 16, 2022, at 7:00 p.m. when R4 was transported via paramedics to a local hospital. R4's Progress Note dated November 18, 2022 at 9:38 a.m., indicated R4 as admitted to the intensive care unit (ICU) at the hospital. R4's Progress Note dated November 21, 2022, at 3:38 p.m., indicated R4 returned under the care of the licensee after a total of five (5) days. R4's record lacked documentation R4 or R4's designated representatives were provided a written notice with the required content. Additionally, R4's record lacked documentation the OOLTC was provided the written notice when the resident did not return within four (4) days. On February 28, 2023, at approximately 2:45 p.m., licensed assisted living director (LALD)-C indicated R4 was not provided any written notice, however licensee had now fully implemented a policy and procedure to provide the written notice with required content to the appropriate parties when an emergency relocation occurs. The licensee's MN Emergency Relocation policy dated September 11, 2022, indicated the written notice with required content would be provided to the resident or resident's representative when an emergency relocation occurred. Additionally, the policy indicated the notice would be provided to the OOLTC if the resident did not return within four (4) days. No further information provided.	01060		

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01060	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (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 observation, interview, and record review, the licensee failed to ensure resident	01650		

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01650	Continued From page 11 service plans included all the required content for four of four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 27, 2023, at 10:15 a.m., the director of nursing (DON)-D stated the licensee provided housekeeping services to residents residing in the facility. On February 28, 2023, at 7:30 a.m., the surveyor observed services for R2 which included dressing, transferring via mechanical lift, catheter care, and hygiene. Unlicensed personnel (ULP)-B stated the licensee also provided housekeeping for R2. R2's service plan dated November 18, 2022, did not include housekeeping services. R3's service plan dated January 18, 2022, did not include housekeeping services. R4's service plan dated February 13, 2023, did not include housekeeping services. R5's service plan dated February 18, 2023, did not include housekeeping services.	01650		

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01650	Continued From page 12 On February 28, 2023, at 2:45 p.m., licensed assisted living director (LALD)-C stated R2, R3, R4 and R5 received laundry services and housekeeping and expected all services provided to residents to be included on their service plans agreement. LALD-C also stated this would be updated with changes and reviewed with all assessments. The licensee's Resident Service Plans policy/procedure updated July 13, 2021, indicated a written (service) plan agreed upon by the resident/resident's designee and the licensee that would provide services that reflected the resident's current assessment and preferences and included the following: -description of services provided; -fees for each service; -frequency of each service; -categories of team members providing services; -schedule and methods of monitoring assessments of the resident; and -schedule and methods of monitoring team members providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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	30282	A. BUILDING: _____ B. WING _____	03/03/2023

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01730	Continued From page 13 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record	01730		

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01730	Continued From page 14 with the required content 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, 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: R4 was admitted on November 24, 2014. R4's Physician Order Sheet dated January 31, 2023, included a provider order which read, "Levothyroxine 125 mcg [microgram] tablet (Levothroid 125 mcg tab) - Take 1 tab by mouth once daily in the morning - 7:30am." The National Institutes of Health/National Library of Medicine (NIH) Levothyroxine drug information sheet retrieved March 2, 2023, at 1:30 p.m., indicated the medication is, "usually is taken once a day on an empty stomach, 30 minutes to 1 hour before breakfast," and additional dietary instructions included, "Some foods and beverages, particularly those that contain soybeans, walnuts, and dietary fiber, may affect how levothyroxine works for you. Talk to your doctor before eating or drinking these foods. Talk to your doctor about eating grapefruit and drinking grapefruit juice while taking this medication." R4's MAR (medication administration record) dated February 2023, indicated R4 received	01730		

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01730	Continued From page 15 Levothyroxine 125 mcg tablet every morning scheduled at 7:30 a.m. R4's Health and Wellbeing Assessment dated February 13, 2023, read under Section 6. Medication Management, "10. Specific resident instructions relating to the administration of medication: A. N/A." On February 28, 2023, at approximately 7:00 a.m., observed unlicensed personnel (ULP)-G provide R4's levothyroxine 125 mcg tablet as ordered. On February 28, 2023, at approximately 2:45 p.m., director of nursing (DON)-D stated R4's assessment lacked specific instructions related to medication management. DON-D indicated instructions such as taking a med before meal or on an empty stomach and avoiding specific foods as indicated by the NIH would be included in R4's medication management. The licensee's Individualized Medication Management Plan policy dated September 13, 2021, indicated specific resident instruction would be included in each resident's medication management record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01880		

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01880	Continued From page 16 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 (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, 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: R4 was admitted on November 24, 2014. R4's Service Agreement dated February 13, 2023, indicated R4 received medication management services two times a day. R4's Health and Wellbeing Assessment dated February 13, 2023, read under Section 6. Medication Management, "6. Medication will be: B. Stored in the client unit. 6.b1. Located: located in locked med safe in laundry room. 6.b2. Secure? Yes. 6.b3 Secured medications can be accessed by: A. Licensed staff." On February 28, 2023, at approximately 7:00 a.m., observed unlicensed personnel (ULP)-G provide R4 medication administration in R4's private room. ULP-G obtained a key from an	01880		

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01880	Continued From page 17 unsecured drawer in R4 wall decoration as ULP-G entered R4's room. ULP-G took the key to R4's laundry room and used the key to open a safe provided by R4's family. Inside the safe were R4's medications. ULP-G dispensed and provided R4 their prescribed meds. ULP-G cleaned up after the medication administration, returned the meds to the safe, and left the safe door open. ULP-G closed the laundry room door and left the unit without securing the medications in R4's room. On February 28, 2023, at approximately 10:45 a.m. director of nursing (DON)-D and surveyor returned to R4's room and observed the safe in the laundry room open and unsecured. DON-D stated the safe should always be locked as R4 should not have access to medications. Additionally, DON-D stated the safe key should not be stored unsecured in R4's room as it would allow R4 to access the medications. The licensee's Medication Administration - Medication Storage policy dated September 5, 2019, indicated medications for residents who received medication management services would be stored based on the nursing assessment. No further information 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	01890		

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01890	Continued From page 18 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for beyond use date of a time-dated drug for one of one resident (R7). 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: During the entrance conference on February 27, 2023, at 10:15 a.m., the director of nursing (DON)-D stated the licensee provided medication management services to residents residing at the facility. On February 28, 2023, between 8:00 a.m. and 8:35 a.m., the licensee's medication cart on the Ponds dementia unit was observed to have the following for R7: - Asmanex HFA 200 micrograms (mcg) inhaler labeled with an opened date of August 2, 2022 - Albuterol HFA 90 mcg inhaler labeled with an opened date of September 27, 2022 On February 28,2023, at 8:10 a.m., unlicensed	01890		

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01890	Continued From page 19 personnel (ULP)-B stated she was not aware of how long each inhaler would maintain its efficacy once opened but "would find out". On February 28,2023, at 8:25 a.m., DON-D provided a pharmacy's "Undated Medications with Shortened Expiration Dating Once Opened" sheet which indicated Asmanaex inhaler expired 45 days once opened and medication for asthma/allergy medications containing Albuterol were effective for 42 days after first activating. DON-D stated both of R7's inhalers would be removed and re-ordered from the pharmacy. The Asmanex HFA 200 mcg undated manufacturer's guideline package insert provided by licensee directed staff to discard the unit when the counter read zero or 45 days after the foil pouch was opened, whichever came first. The Albuterol HFA 90 mcg undated manufacturer's guideline package insert provided by licensee undated directed staff to discard upon expiration date or when counter was at zero, whichever came first. R7's Medication administration record (MAR) for February 2023 indicated Asmanex HFA 220 mcg was administered every day as ordered February 1, 2023, through February 27, 2023. R7's MAR also indicated Albuterol HFA 90 mcg was administered on an "as needed" basis but was not used during the stated time. On February 28, 2023, at approximately 2:45 p.m., licensed assisted living director (LALD)-C stated she expected licensed staff to oversee safe and appropriate storage of medications including medications which had a shortened expiration date once opened.	01890		

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01890	Continued From page 20 The licensee's Medication Administration-Medication Storage Policy and Procedure dated July 19, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as	02170		

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02170	Continued From page 21 entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation for two of two residents (R2, R3) with dementia. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included other symptoms and signs involving cognitive function and awareness. R2 resides in the licensee's secured dementia unit.	02170		

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02170	Continued From page 22 R2's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. R2's service plan/care plan dated November 18, 2022, lacked development or indication of an activity program. R3 R3's diagnoses included dementia. R3 resided in the licensee's secured dementia unit. R3's record lacked an evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R3's record lacked the development of an individualized activity plan. R3's service plan/care plan dated January 4, 2023, lacked the development or indication of an activity program. On February 28. 2023, at 12:30 p.m., director of nursing (DON)-D stated although the "Petals Life	02170		

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02170	Continued From page 23 Story Assessment" was completed by family/representatives of R2 and R3, the assessment lacked the required content as listed above. In addition, DON-D further stated an individualized activity care plan with interventions was not developed or operationalized for either resident. The [licensee] Life Enrichment and Implementation of Activities (Active Life) policy revised July 30, 2021, indicated upon admission to the community, the resident, family, or other representative would complete a survey/assessment. Staff would meet with the resident and/or families to review the survey/assessment to determine individual preferences, interests and likes. An activity plan would be maintained and updated as the resident preferences or interests changed. A daily program of social and recreational activities would be offered based upon individual and group interests, physical, mental, and psychosocial needs, and one that created opportunities for active participation in the community at large. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02350 SS=C	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by:	02350		

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02350	Continued From page 24 Based on observation, interview, and record review, the licensee failed to ensure resident's property was treated with dignity and respect when receiving medications for two of two residents (R4, R5) observed during medication pass. 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 the potential to affect a large portion or all the residents). The findings include: R2 was admitted September 20, 2021. R2's Service Agreement dated November 18, 2022, indicated R2 received medication management service. R3 was admitted January 3, 2023. R3's Service Agreement dated January 18, 2023, indicated R3 received medication management service. R4 was admitted November 1, 2014. R4's Service Agreement dated February 13, 2023, indicated R4 received medication management service. R5 was admitted April 6, 2022. R5's Service Agreement dated February 18, 2023, indicated R5 received medication	02350		

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02350	Continued From page 25 management service. On February 28, 2023, at approximately 7:00 a.m., unlicensed personnel (ULP)-G provided medication management service to R4 and R5. ULP-G performed hand hygiene in each resident's room prior to and after ULP-G provided services. ULP-G would wash their hands in the resident's kitchen sink and dry their hands with paper towels located on each resident's kitchen counter. ULP-G stated the licensee provided paper towels to each resident when a resident required services, however some residents purchased their own paper towels as the residents may prefer a softer or decorative paper towel. ULP-G stated if a resident did purchase their own paper towels, the ULPs would use them instead of the licensee supplied paper towels. On February 28, 2023, at 8:30 a.m., licensed assisted living director (LALD)-C stated licensee supplied paper towels to resident when residents begin to receive services. LALD-C stated ULPs are trained to use whatever paper towels are located inside the resident apartments, even if the paper towels are the residents' own privately purchased paper towels. On February 28, 2023, at 11:00 a.m., LALD-C stated ULPs are not trained to recognize the residents' personal paper towels compared to the licensee supplied paper towels. LALD-C stated each ULP will be trained to identify the difference and use only the licensee supplied paper towels. LALD-C indicated licensee recognized how using resident's personal paper towels would not be respecting resident's personal property. The licensee's Safe Keeping of Resident's Possessions policy dated July 29, 2021, indicated	02350		

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02350	Continued From page 26 the licensee would take precautions to ensure the safety of resident's belongings. The policy did not address licensee's employees using residents' personal property. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

DEPARTMENT OF HEALTH

Type: Full
Date: *02/27/23*
Time: 13:00:00
Report: 1036231034

Food and Beverage Establishment Inspection Report

Location:
The Waters On 50th
3500 50th Street West
Minneapolis, MN55410
Hennepin County, 27

Establishment Info:
ID #: 0038601
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122009552
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO DEVICE AT ESTABLISHMENT FOR MEASURING THE SURFACE TEMP IN THE HOT WATER DISH MACHINE. OBTAIN AND MAINTAIN A IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR.

Comply By: 03/06/23

4-600 Cleaning Equipment and Utensils

4-602.12

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

OBSERVED SOME ENCRUSTED FOOD RESIDUE IN THE MICROWAVE. CLEAN AND MAINTAIN.

Comply By: 02/28/23

Surface and Equipment Sanitizers

HOT WATER: = at 160.4 Degrees Fahrenheit
Location: KITCHEN DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: KITCHEN SANI BUCKET
Violation Issued: No

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: SERVING LINE SANI BUCKET
Violation Issued: No

QUATERNARY AMMONIA: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: TRUE DOUBLE DOOR REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: SMALL LOBBY FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 1 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Process/Item: Hot Holding/SOUP
Temperature: 176 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF ERIK SALO. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR BRANDON MUELLER FOLLOWING THE INSPECTION.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE
- REHEATING PROCEDURES
- COOLING PROCEDURES
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

Type: Full
Date: *02/27/23*
Time: 13:00:00
Report: 1036231034
The Waters On 50th

Food and Beverage Establishment Inspection Report

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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

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

I acknowledge receipt of the inspection report number 1036231034 of 02/27/23.

Certified Food Protection Manager: Erik J. Salo

Certification Number: FM51901 Expires: 11/25/23

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: 

Erik Salo
Food Manager

Jeff Johanson