Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 19, 2024

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

RE: Project Number(s) SL32917016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents no violations. MDH documents the state correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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

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

If you have any questions, please contact me.

Sincerely,

-

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39806	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY HOMES LLC	6436 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: SL39806015-0 On October 14, 2024, through October 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four resident(s); four receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 15, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 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 effective infection control program that complied with accepted health care, and medical and nursing standards for infection control for one of two unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 October 15, 2024, at 7:19 a.m., the surveyor observed ULP-F enter R1's bedroom with a small black carry case that contained a blood pressure machine. ULP-F placed the blood pressure cuff onto R1's right arm and started the machine. After the machine had registered the blood pressure, using a cellular phone, ULP-F entered the information into RTasks (an electronic	0 510		

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0 510	Continued From page 3 medical record). Without wiping down the blood pressure cuff, ULP-F placed the blood pressure machine back into the small black carry case. ULP-F walked into the common area, unlocked the medication cart and placed the blood pressure machine into the second drawer. On October 15, 2024, at 7:51 a.m., ULP-F stated the blood pressure machine was used for two residents. ULP-F stated they were trained by the registered nurse to wipe down the blood pressure machine after use and forgot to wipe it down after using it on R1. On October 15, 2024, at 8:03 a.m., owner/licensed assisted living director/registered nurse (O/LALD/RN)-D stated staff were trained to wipe down the blood pressure machine after each use. O/LALD/RN-D stated the blood pressure cuff should have been wiped down before it was placed into the carry case. On October 15, 2024, at 11:52 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to wipe down the blood pressure cuff after each use. CNS-C stated the blood pressure cuff should have been wiped down and that situation should not have occurred. The licensee's 8.01 Infection Control Policy dated September 1, 2023, indicated [licensee] infection control practices would be consistent with current guidelines from center for disease control (CDC). The licensee 8.03 Cleaning Share Medical Equipment policy dated September 1, 2023, indicated [licensee] would maintain processes that ensured all reusable equipment was disinfected before and after use.	0 510		

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0 510	Continued From page 4 The CDC Disinfection of Healthcare Equipment guidance, dated November 23, 2023, indicated it was a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection agency (EPA) registered low or intermediate level disinfectant. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01880 SS=F	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 store prescription medication securely to permit only authorized personnel to have access. 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).	01880		

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01880	Continued From page 5 The findings include: R2 was admitted to the licensee on May 6, 2024, and began to receive assisted living services. R2's assessment dated August 5, 2024, indicated the licensee would store all the medications in a locked cabinet. On October 14, 2024, at 10:41 a.m., during a facility tour, in the lower level of the split-level facility, the surveyor observed lidocaine and prilocaine cream 2.5 percent (%)/2.5 % on the dresser in R2's room. On October 14, 2024, at 1:38 p.m., unlicensed personnel (ULP)-E stated if they observed medications in resident rooms, they were trained to remove medications and to contact the registered nurse (RN). ULP-E stated they were unaware of medications in R2's room. On October 14, 2024, at 1:53 p.m., owner/licensed assisted living director/registered nurse (O/LALD/RN)-D stated staff were trained to remove medications from resident rooms. O/LALD/RN-D stated the lidocaine and prilocaine 2.5/2.5% cream was used on the resident's fistula (a surgically created access for residents to be able to receive dialysis (a treatment that performs the actions of the kidneys when they do not function)). O/LALD/RN-D stated the cream was applied by staff at the dialysis unit and R2 received dialysis treatment on Tuesday, Thursday, and Saturday. O/LALD/RN-D stated the medication should not be with R2 and should be stored at the dialysis unit. O/LALD/RN-D stated they did not have a prescriber's order and was not responsible for ordering or storing the medication. O/LALD/RN-D was unsure why R2	01880		

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01880	Continued From page 6 had the medication in their room. On October 15, 2024, at 11:56 a.m., clinical nurse supervisor (CNS)-C stated all resident medication should be stored in the locked medication cart. CNS-C stated the lidocaine and prilocaine 2.5/2.5 % cream was used at the dialysis unit and was sent home with the resident after treatment. CNS-C stated there was not an order for the medication and the medication should not had been in the resident room. The licensee's 7.11 Medication Storage policy dated September 1, 2023, indicated [licensee] would only allow authorized staff to have access to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three	02320		

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02320	Continued From page 7 residents (R1). Additionally, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-E) followed appropriate medication administration procedures. 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: ULP-E On October 14, 2024, at 11:51 a.m., the surveyor observed ULP-E unlock the medication cart in the common room of the split-level assisted living facility. ULP-E removed a medication bubble card which contained the following information, "[R2] October 14/24 Mon Noon 1-sevelamar 800 mg tab." Without verifying the medication, ULP-E removed the bubble tab and placed it into a medication cup. On October 14, 2024, at 11:56 a.m., the surveyor observed R2 walk upstairs into the common area where ULP-E and the medication cart were located. ULP-E requested R2 state their name and date of birth. R2 answered the request. ULP-E opened the bubble tab with the medication and placed it into the medication cup. ULP-E handed the medication cup to R2. In the interest of safety, the surveyor intervened as the medication had not been verified by ULP-E. On October 14, 2024, at 11:58 a.m., ULP-E	02320		

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02320	Continued From page 8 stated they were trained to verify medications prior to administering to residents by opening the electronic medication administration record (EMAR), comparing the medication to the EMAR, clicking verify on the EMAR, then administering. ULP-E stated they forgot to verify the medication on the EMAR. On October 14, 2024, at 12:01 p.m., owner/licensed assisted living director/registered nurse (O/LALD/RN)-D stated staff had to ensure they had the right resident, correct dose, and right route before administering medications. O/LALD/RN-D stated staff were trained to verify the medications against the EMAR prior to administration. O/LALD/RN-D stated there was confusion with the surveyor observing and staff were nervous. On October 15, 2024, at 11:55 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to verify medication against the EMAR prior to medication administration. CNS-C stated ULP-E was nervous while being observed. The licensee's 7.31 Oral Medication policy dated September 1, 2023, indicated staff would compare the medication administration record prior to administering medications to residents. R1 R1 was admitted to the licensee on February 1, 2024, and began to receive assisted living services. R1's diagnoses included amputation of left leg below the knee, anxiety, sleep disorder, osteoarthritis (breakdown of the tissue in joints), hypercholesteremia (high cholesterol), Diabetes type one, hypertension (high blood pressure),	02320		

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02320	Continued From page 9 constipation, third nerve palsy (nerve that controls eye coordination is damaged), major depressive disorder, peripheral vascular disease (narrowing of blood vessels), and muscle weakness. R1's Service Plan - Modification dated April 30, 2024, indicated R1 received assistance with medication administration. R1's assessment dated September 28, 2024, indicated the licensee would store all medications for R1. R1 medical orders signed August 7, 2024, indicated R1 received the following medications: amlodipine 10 milligram (mg) 1 tablet once daily, aspirin 81 mg 1 tablet once daily, atorvastatin 80 mg 1 tablet once daily, chlorthalid 50 mg 1 tablet once daily, clopidogrel 75 mg 1 tablet once daily, famotidine 75 mg 1 tablet once daily, fiber-lax 625 mg 1 tablet once daily, Lantus Solostar 100 units (u) / milligram (ml) 18 units under the skin at bedtime, losartan potassium 100 mg 1 tablet once daily, melatonin 5 mg 1 tablet at bedtime, metoprolol 25 mg extended release (ER) once daily, omeprazole 20 mg capsule once daily, Ozempic 0.25-0.5 mg 1 capsule once daily, polyethylene glycol 3350 powder dissolve 17 grams (gm) in 8 ounces of liquid, sertraline 100 mg 1 tablet once daily, acetaminophen 325 mg 2 tablets every six hours as needed, nasogel gel apply to nasal passages topically (on the skin) twice daily as needed, and senna plus 8.6-50 mg 1 tablet as needed. On October 15, 2024, at 7:16 a.m., the surveyor observed ULP-F and O/LALD/RN-D in the kitchen on the upper level of the split-level facility filling a large blue cup with water.	02320		

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02320	Continued From page 10 On October 15, 2024, at 7:37 a.m., the surveyor observed ULP-F take the polyethylene glycol 3350 powder bottle out of the medication cart. Using the lid of the medication bottle, ULP-F poured the polyethylene glycol 3350 powder to the required fill line and dumped the powder into a red plastic tumbler that contained water. ULP-F placed the polyethylene glycol 3350 powder back into the medication cart and locked the cart. O/LALD/RN-D gave ULP-F a metal spoon from the kitchen to stir the liquid that contained the powder. On October 15, 2024, at 7:44 a.m., with the red tumbler that contained the polyethylene glycol 3350 powder and a metal spoon, ULP-F entered R1's room located up the upper level. By R1's hospital bed was a bedside table that contained the large blue drinking cup with a straw and lid. ULP-F opened the lid from the blue drinking cup, and poured the content of the red tumbler into the blue container that already contained a liquid. ULP-F poured liquid from the blue cup back to the red tumbler, mixed the two liquids with the spoon and pour the content from the red tumbler back into the blue drinking cup. The blue drinking cup was observed to be more than one-half full. ULP-F placed the lid back onto the blue cup, and presented the straw to R1 to allow them to drink. R1 used the straw twice. ULP-F placed the blue container back onto the bedside table. There was no way to determine how much of the medication R1 had received. On October 15, 2024, at 7:51 a.m., the surveyor observed ULP-F use a cellular phone to document in RTasks (a medical charting program) and documented the polyethylene glycol 3350 powder as administered to R1. ULP-F left R1's room. The medication was left	02320		

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02320	Continued From page 11 unsecured by staff. On October 17, 2024, at 7:57 a.m., ULP-F stated they were not trained to perform that action by the registered nurse (RN). ULP-F stated this was a new medication for R1. ULP-F stated they transferred the liquid between the red tumbler and blue drinking container to dissolve all the powder. On October 17, 2024, at 8:05 a.m., O/LALD/RN-D stated they believed the medication was secured if it was left in the blue drinking cup in R1's room.and only staff would access R1's room. O/LALD/RN-D stated the medication would be administered if R1 consumed all the content from the blue drinking cup. O/LALD/RN-D stated staff were trained to have R1 drink the content from the red drinking tumbler and not to mix the medication with other liquid. On October 17, 2024, at 12:02 p.m., CNS-C stated staff were not allowed to leave medications in residents rooms unsupervised. CNS-C stated ULP-F should not have left the polyethylene glycol 3350 powder with the resident. CNS-C stated staff were trained to ensure all medications were consumed and then document as administered. The licensee's 7.39-1 Oral Medication policy dated September 1, 2023, indicated [licensee] would ensure staff administer medications in accordance with physician orders, regulatory standards, and individual care plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02320		

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02320	Continued From page 12 days	02320		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *10/15/24*
Time: 10:00:00
Report: 1047241284

Food and Beverage Establishment Inspection Report

Location:
Tranquility Homes LLC
6436 Scott Ave N
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0043699
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SAUSAGE LOCATED ON TOP OF READY TO EAT DELI MEAT. CORRECTED ON SITE-SAUSAGE WAS RELOCATED.

Comply By: 10/15/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- sausage
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator K. Langley.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential

dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1047241284 of 10/15/24.

Certified Food Protection Manager: Jane M. Kungu

Certification Number: FM115700 Expires: 03/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Jane Kungu
Operator

Signed: _____

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