



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2025

Licensee

Inver Grove Heights White Pine

9056 Buchanan Trail

Inver Grove Heights, MN 55077

RE: Project Number(s) SL30696016

Dear Licensee:

On November 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 17, 2025. 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,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2025

Licensee

Inver Grove Heights White Pine

9056 Buchanan Trail

Inver Grove Heights, MN 55077

RE: Project Number(s) SL30696016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE			STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077		
(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: SL30696016-0 On July 14, 2025, through July 17, 205, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 55 residents; 55 receiving services under the Assisted Living Facility license. 1750: An immediate order was issued on July 15, 2025, at a level 3/Widespread (I) The licensee took action on July 15, 2025; however, the scope and level remain at I.	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.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee had an assisted living license, effective June 1, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on March 24, 2025. As a result of this survey, the following orders were issued under 0480, 0630, 0640, 0700, 0775, 0800, 0950, 1060, 1460, 1530, 1620, 1640, 1700, 1730, 1750, 1760, 1770, 1890, 1910, 1940, 1950, 1970, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 4 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 July 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 630	Continued From page 5	0 630			
0 630 SS=F	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 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 the required content for three of three residents (R1, R2, and R3). 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: R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes.	0 630			

Minnesota Department of Health

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0 630	Continued From page 6 On July 14, 2025, at 11:58 a.m., the surveyor observed unlicensed personnel (ULP)-E administer insulin to R1. R1's service plan dated June 28, 2025, indicated R1 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, reassurance checks, toileting assistance, diabetic management, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties), oxygen, medication management, and medication administration. R1's IAPP dated March 30, 2025, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. On July 15, 2025, at 8:43 a.m., the surveyor observed ULP-E administer medications to R2. R2's service plan dated June 24, 2025, indicated R2 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, oral care, escorts, transfer assistance, turn and repositioning, reassurance checks, behavior intervention, toileting assistance, incontinent care, vital signs/weight, blood glucose monitoring, diabetic management, medication management, and medication administration.	0 630			

Minnesota Department of Health

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0 630	Continued From page 7 R2's IAPP dated February 10, 2025, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). On July 15, 2025, at 7:40 a.m., the surveyor observed ULP-F administer medications to R3. R3's service plan dated July 14, 2025, indicated R3 received services to include bathing assistance, dressing and grooming, meals, feeding assistance, fingernail and toenail care, oral care, glasses, vital signs/weight, smoking, assist hooyer lift transfers, turn and repositioning, bed mobility, behavior intervention, reassurance checks, siderails, catheter care, incontinent care, range of motion, brace application/removal, wound care, medication management and medication administration. R3's IAPP dated October 17, 2024, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On July 16, 2025, at 11:38 a.m., regional registered nurse (RRN)-H reviewed the IAPPs and stated the plan did not include an area to	0 630			

Minnesota Department of Health

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0 630	Continued From page 8 assess residents' susceptibility to abuse by another individual, including other vulnerable adults. RN-H stated the same IAPP document was used for all residents. The licensee's Individual Abuse Prevention Plan policy dated April 1, 2025, indicated the licensee would develop an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults 2. For purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number	0 640			

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0 640	Continued From page 9 for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, 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, 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 July 14, 2025, at 9:50 a.m. during the facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, the surveyor did not observe any signage or information posted regarding the 911 emergency number. On July 16, 2025, at 11:33 a.m., LALD-A stated the did not have the 911 emergency number posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 640			

Minnesota Department of Health

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0 640	Continued From page 10 (21) days	0 640			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within 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) 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 July 14, 2025, at 9:50 a.m. during the facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, the surveyor was shown a room that had a kitchenette and large tablet in it. CNS-C stated the room was available for staff, residents, and	0 700			

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NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE			STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077		
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0 700	Continued From page 11 visitors. CNS-C stated the staff used this room for shift-to-shift report. CNS-C pointed out four binders sitting on the counter, and further stated one of them was the communication book used by staff for resident updates. On July 15, 2025, at 6:47 a.m., the surveyor noted four binders in the room that staff used for shift-to-shift report. The doors to the room were open. All four binders contained resident information which included resident room numbers, resident names, personal health and medical information regarding change in condition and services provided by staff. On July 16, 2025, at 11:34 a.m., CNS-C stated the four binders included private medical information for residents and was accessible to anyone who had access to the room. The licensee's Resident Record- Confidentiality policy dated April 1, 2025, indicated resident records will be kept confidential and locked in a secure area where only authorized staff have access to. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775			

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0 775	Continued From page 12 by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, 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: During facility tour on July 17, 2025, from 10:10 a.m. through 11:40 a.m. with maintenance personnel (MP)-K, the surveyor observed fire rated doors that were not maintained to automatically close and latch as designed in the following locations: Third floor storage room doors had closers mounted at the top of the door. The closer arms had been removed. Second floor center stairway door was one-hour fire rated with a closer mounted at the top of the door. The door was hitting the floor did not close and latch. Second floor elevator lobby had two one-hour fire rated doors with a closer mounted at the top of the doors. The doors hit the door frame and did not close and latch. One door had the latch removed. The first-floor kitchen and resident room 14 had	0 775			

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0 775	Continued From page 13 20-minute fire rated doors with a closer mounted at the top of the doors. The doors did not close and latch. MP-K stated the hinges needed to be adjusted or replaced. The main floor dining room had double 20-minute fire rated doors that were held open with magnetic door holds. When the doors were released from the magnetic holds, they did not automatically close. State Fire Code in MN Rules, chapter 7511 requires fire rated doors to be maintained to self-close and latch as designed. During same tour the surveyor observed gas furnaces located in closets in resident bedrooms. Resident units 61, 47, 16, 14 and 6 had combination smoke/carbon monoxide alarms located outside the bedroom that contained the gas furnace and smoke alarms located inside the bedroom. MP-K stated that all resident units had gas furnaces, and they would check all units to make sure the carbon monoxide alarms were in the bedroom where the furnace is located. State Fire Code in Minnesota Rules, chapter 7511 requires carbon monoxide alarms be provided in sleeping rooms that contain a fuel burning appliance. MP-K verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 14 (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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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: During facility tour on July 17, 2025, from 10:10 a.m. through 11:40 a.m. with maintenance personnel (MP)-K, the surveyor observed the following: There was a hole in the drywall behind the second-floor center stairway door. MP-K stated it was from the door handle hitting the wall.	0 800			

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0 800	Continued From page 15 The ceiling had drywall damaged and falling in the second-floor mechanical room by resident room 32. MP-K stated the third-floor condenser unit had leaked and caused water damage. The stairway by resident room 37 led to the exterior. The exterior door frame was rusting and falling apart at the bottom. The siding at the bottom on each side of the door was disintegrating. MP-K stated it was from water ponding in that location. The main floor electric closet by resident room 17 had drywall next to the door that was loose and falling off the wall. MP-K stated they would screw the drywall back in place. The carpet on the center stairs was torn and had holes worn through in several spots. Resident room six bathroom fan was not working. MP-K stated they would have it replaced. Resident room two bathtub faucet was leaking and there were black stains on the tub around the drain. MP-K stated the resident was gone so it must have been leaking for a while. MP-K visually verified the above findings while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950			

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0 950	Continued From page 16 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for three of three residents (R1, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 950			

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0 950	Continued From page 17 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes. R1's service plan dated June 28, 2025, indicated R1 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, reassurance checks, toileting assistance, diabetic management, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties), oxygen, medication management, and medication administration. R1's Resident Agreement dated March 31, 2025, included an area to designate or decline a designated representative; however, it was left blank, and the agreement lacked a separate page for designated representative to include the required verbiage. R1's record lacked evidence in writing of providing on a document separate from the contract verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information	0 950			

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0 950	Continued From page 18 related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. R2's service plan dated June 24, 2025, indicated R2 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, oral care, escorts, transfer assistance, turn and repositioning, reassurance checks, behavior intervention, toileting assistance, incontinent care, vital signs/weight, blood glucose monitoring, diabetic management, medication management, and medication administration. R2's Resident Agreement dated April 25, 2023, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R2's record lacked evidence in writing of providing on a document separate from the contract verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not	0 950			

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0 950	Continued From page 19 take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R3 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). R3's service plan dated July 14, 2025, indicated R3 received services to include bathing assistance, dressing and grooming, meals, feeding assistance, fingernail and toenail care, oral care, glasses, vital signs/weight, smoking, assist hoier lift transfers, turn and repositioning, bed mobility, behavior intervention, reassurance checks, siderails, catheter care, incontinent care, range of motion, brace application/removal, wound care, medication management and medication administration. R3's Resident Agreement dated April 25, 2023, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R3's record lacked evidence in writing of providing on a document separate from the contract verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your	0 950			

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0 950	Continued From page 20 behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On July 16, 2025, at 11:55 a.m., licensed assisted living director (LALD)-A stated all of the licensee's resident agreements did not include the required notice for designation of representative with the required verbiage on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01060 SS=F	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	01060			

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01060	Continued From page 21 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.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 and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (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	01060			

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01060	Continued From page 22 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5 was admitted on March 1, 2024, with diagnoses that included coronary artery disease (damage or disease in the heart's major blood vessels). R5's progress notes dated January 22, 2025, indicated R5 was sent to the emergency room via emergency medical services (EMS) after experiencing nausea, vomiting, and severe abdominal pain. R5 was admitted to the hospital. R5's progress notes dated March 5, 2025, indicated R5 resided at transitional care unit (TCU) for short term rehabilitation. R5's progress notes dated June 2, 2025, indicated R5 was discharged from TCU to a skilled nursing facility for long term placement. R5's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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; - 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	01060			

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01060	Continued From page 23 information for the agency to which the resident may submit an appeal. In addition, R5's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On July 16, 2025, 12:23 p.m., clinical nurse supervisor (CNS)-C and registered nurse (RN)-D stated R5's record lacked evidence a written notice related to R5's emergency relocations had been completed and provided, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. CNS-C and RN-D further stated they were not aware of the requirement. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the	01460			

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01460	Continued From page 24 staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-F) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01460			

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01460	Continued From page 25 situation has occurred only occasionally). The findings include: ULP-F was hired on April 21, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On July 16, 2025, at 12:03 p.m., assistant manager (AM)-B reviewed ULP-F's training transcript and records and stated ULP-F had not been assigned or completed orientation to assisted living facility licensing requirements. AM-B stated it was an oversight that ULP-F was not assigned the required orientation training. The licensee's Orientation of Staff and supervisors and Content policy dated April 1, 2025, indicated all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the	01460			

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01460	Continued From page 26 following topics: -an overview of appropriate Assisted Living statues and rules -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -principles of person-centered planning ad service delivery and how they apply to direct support services provided by the staff person -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the department of Human Services, county-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee will be providing and the facility's category of licensure No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530			

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01530	Continued From page 27 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

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01530	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-F received the required amount of dementia, mental illness, and de-escalation training in the required time frame. 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: The licensee provided services under an Assisted Living Facility license. ULP-F was hired on April 21, 2023, to provide direct care and services to the facility's residents. ULP-F's employee record contained evidence the employee received 3.5 hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-F's employee record lacked evidence of completing any mental illness, and de-escalation training On July 16, 2025, at 12:06 p.m., assistant	01530			

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01530	Continued From page 29 manager (AM)-B reviewed ULP-F's training transcript and records and stated ULP-F had completed 3.5 hours of initial dementia care training and not the required eight hours. AM-B stated ULP-F had not completed any mental illness and de-escalation training. The licensee's Dementia Training policy dated April 1, 2025, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must	01620			

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01620	Continued From page 30 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 14 days from admission for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620			

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01620	Continued From page 31 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: R1 was admitted on April 15, 2025, with diagnoses that included diabetes. R1's service plan dated June 28, 2025, indicated R1 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, reassurance checks, toileting assistance, diabetic management, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties), oxygen, medication management, and medication administration. R1's ongoing nursing assessments were requested. Assessments dated April 16, 2025, and May 14, 2025, were provided. The May 14, 2025, assessment was completed 28 days after the date of admission, thus exceeding 14 calendar days. On July 16, 2025, at 11:41 a.m., clinical nurse supervisor (CNS)-C stated R1's 14-day assessment was started April 29, 2025; however, it was not completed until May 14, 2025. CNS-C stated sometimes the assessments are finished and marked complete later if they are waiting for additional information to add to the assessment. The licensee's Assessment Schedules policy	01620			

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01620	Continued From page 32 dated April 1, 2025, indicated a uniform assessment would be completed on or before 14 days after start of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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. (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 a written	01640			

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01640	Continued From page 33 service plan was revised to reflect the current services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on April 25, 2023, with diagnoses that included diabetes. On July 15, 2025, at 8:43 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood sugar and administer medications. R2's service plan dated June 24, 2025, indicated R2 received services to include bathing assistance, dressing and grooming, meals, diabetic nail and footcare, comprecare (type of compression stocking to reduce swelling in legs) oral care, escorts, transfer assistance, turn and repositioning, reassurance checks, behavior intervention, toileting assistance, incontinent care, monthly vital signs/weight, blood glucose monitoring, diabetic management, medication management, and medication administration. R2's service plan did not include weekly weights, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties) or Libre sensor changes. R2's medication administration record (MAR)	01640			

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01640	Continued From page 34 dated July 2025, included the following services: -BIPAP: off at 8:00 a.m., and on at 10:00 p.m. -Freestyle Libre Reader, continuous blood receiver -Weekly Weights; weight resident weekly on Wednesday morning. Notify nursing with >3 pounds. On July 16, 2025, at 11:42 a.m., registered nurse (RN)-D reviewed R2's signed service plan and stated it did not include weekly weights, BIPAP or Libre sensor changes. RN-D stated R2's service plan was recently updated, which included these treatments; however, an updated service plan was not provided to the surveyor. The licensee's Service Plan policy dated April 1, 2025, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided.	01700			

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01700	Continued From page 35 This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R2) who self-administered medications was assessed for self-administration of medications. 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:	01700			

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01700	Continued From page 36 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. R2's service plan dated June 24, 2025, indicated R2 received services to include medication management, and medication administration. On July 15, 2025, at 8:43 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral medications and insulin to R2. The surveyor noted four bottles of medication (one bottle of turmeric, one bottle of A-Z supplement and two bottles of probiotics) sitting on R2's side table. R2 stated she self-administered the medication in the bottles once a week. R2's record lacked prescriber orders for turmeric, A-Z supplements, and probiotics. R2's individualized medication management plan dated June 30, 2025, indicated the following: 1. Was the assessment completed face to face with the resident or representative? -Yes 2. What medication management services will be provided by the facility? -Medication administration by an unlicensed personnel 3. Will resident Self-Administer medications? If Yes: Complete Self administration assessment: -No 4. Ability to Self-Manage Medications (See Assessment for Safety in Self-Administration of Medications): -Resident is deemed unable to safely self-administer medications for the following reasons: resident is dependent on all care, not independent with mobility and can be forgetful.	01700			

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01700	Continued From page 37 On July 16, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-C stated R2 did not have a self-administration of medication assessment because R2 should not self-administer any medications. CNS-C stated R2's family must have brought them in for her as they have in the past. CNS-C stated staff should notify the nurse if they see any medications in R2's room. The licensee's Medication and Treatment-Administration and Delegation policy dated April 1, 2025, indicated a RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided. The licensee's Medication Management-Administration and Setup policy dated April 1, 2025, indicated a resident will either administer all medications independently or staff will administer medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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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(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
01730	Continued From page 38 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	01730			

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01730	Continued From page 39 individualized medication management plan with the required content for three of three residents (R1, R2, and R3). 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 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: During the entrance conference on July 14, 2025, at approximately 9:20 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the residents at the facility. CNS-C stated medications were stored in the medication cart, refrigerator, and medication room. R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes. R1's service plan dated June 28, 2025, indicated R1 received services to include medication management, and medication administration. On July 14, 2025, at 11:58 a.m., the surveyor observed unlicensed personnel (ULP)-E administer insulin to R1. ULP-E stated insulin was stored in the refrigerator until used. Once an insulin pen was used, it was kept in the medication cart.	01730			

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01730	Continued From page 40 R1's individualized medication management plan dated May 14, 2025, indicated: -medications were stored in the medication cart On July 16, 2025, at 11:45 a.m., registered nurse (RN)-D reviewed R1's medication plan and stated the plan should indicate R1's insulin was stored in the secured refrigerator. RN-D stated the licensee did not include the central medication room as a storage option in any of the resident's medication plans. RN-D stated all resident overflow medications were stored in the medication room. R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. R2's service plan dated June 24, 2025, indicated R2 received services to include medication management, and medication administration. On July 15, 2025, at 8:43 a.m., the surveyor observed ULP-E administer oral medications and insulin to R2. The surveyor noted four bottles of medication (one bottle of turmeric, one bottle of A-Z supplement and two bottles of probiotics) sitting on R2's side table. R2 stated she self-administered the medication in the bottles once a week. R2's record lacked prescriber orders for turmeric, A-Z supplements and probiotics. R2's individualized medication management plan dated June 30, 2025, indicated: -Resident is deemed unable to safely self-administer medications for the following reasons: resident is dependent on all care, not independent with mobility and can be forgetful.	01730			

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01730	Continued From page 41 -medications were stored in the medication cart, medication narcotic box and refrigerator. On July 16, 2025, at 11:47 a.m., CNS-C reviewed R2's individualized medication plan and stated R2 should not self-administer any medications. CNS-C stated R2's family must have brought them in for her as they have in the past. CNS-C stated staff should notify the nurse if they see any medications in R2's room. CNS-C stated R2's medication plan did not include medications stored in the central medication room. R3 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). R3's service plan dated July 14, 2025, indicated R3 received services to include medication management and medication administration. On July 15, 2025, at 7:40 a.m., the surveyor observed ULP-F prepare R3's medications and bring them to her room to administer. ULP-F went to R3's side table in her bedroom and opened a bottle of apple cider vinegar, removed one tablet and placed it in the medication cup with R3's other medications. ULP-F administered the medications to R3. The surveyor inquired about the apple cider vinegar tablet and R3 stated the staff administered it to her for weight loss. ULP-F stated every morning the ULP would remove one tablet from the bottle and add it to the rest of R3's medications. The surveyor also noted a bottle of multivitamins on the same table. ULP-F stated the vitamins were administered to R3 later. R3's record lacked prescriber orders for apple	01730			

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01730	Continued From page 42 cider vinegar tablets. R3's individualized medication management plan dated June 12, 2025, indicated: -medication management services included: medication administration by ULP and medication setup by a nurse -medications were stored in the medication cart On July 16, 2025, at 11:51 a.m., CNS-C stated R3 did not have medication setup services, and it should not be included in her medication plan. CNS-C stated the nurses were not aware that R3 kept any medications in her bedroom and that staff administered them to R3. CNS-C stated R3's medication plan did not include medications are stored in the central medication room. The licensee's Medication Management Individualized Plan policy dated April 1, 2025, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when	01730			

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01730	Continued From page 43 a problem arises with medication management services, and g. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure unlicensed personnel (ULP) had been trained and competency tested by a licensed registered nurse (RN) prior to administering medications. This resulted in an immediate correction order identified on July 15, 2025. In addition, the licensee failed to ensure the	01750			

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01750	Continued From page 44 RN documented resident-specific instructions for three of three residents (R1, R2 and R3). 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). The findings include: On July 14, 2025, at approximately 9:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A and assistant manager (AM)-B stated when a new ULP is hired they are scheduled to a minimum of three days on the floor training for medication administration. On day one, the new ULP would shadow and observe the trainer passing medications to residents. On day two, the new ULP starts to assist the trainer with medication administration. On day three, the new ULP completes the entire medication pass while the trainer shadows and observes the new ULP. After the ULP have completed the three days of training, the nurse will meet with them to competency test them on medication management tasks. On July 15, 2025, at 6:53 a.m., ULP-G stated she was hired in May of 2025, as a caregiver and a medication passer. The surveyor inquired how she was trained on medication management services. ULP-G stated she had to complete several Educare (training software) courses before she could do any training on the floor. Once she completed Educare, she had three	01750			

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01750	Continued From page 45 days of training on the medication cart. ULP-G stated on the first day, she watched the trainer complete all the medication tasks. On the second day, she set up and administered some of the resident's medications with the oversight of the trainer. On the third day, ULP-G stated she completed all medication management tasks assigned to her while the trainer was around and available to assist if needed. ULP-G stated after the three days of training, she was asked if she was comfortable with passing medications or if she needed more training dates. ULP-G stated she was comfortable, and was scheduled to meet with the nurse to be competency tested a few days later. On July 15, 2025, at 11:20 a.m., the surveyor met with regional registered nurse (RRN)-H, clinical nurse supervisor (CNS)-C, LALD-A, and AM-B to review the licensee's procedure for ULP competency testing on medication management services. AM-B stated new ULP are scheduled to train for three days. On day one, the new ULP observed the trainer complete all medication management tasks. On day two, the new ULP would administer medications and insulin to some of the residents while the trainer completed most of the medication management tasks. On day three, the new ULP would administer all medication tasks (oral medications, insulin, topicals, etc.) for all residents and could utilize the trainer as needed. After the third day of training, if the ULP was comfortable with medication management tasks, then the RN would set up a time for the new ULP to demonstrate competency with medication management tasks. CNS-C and LALD-A stated this was an accurate explanation of the training process for medication management tasks.	01750			

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01750	Continued From page 46 The licensee's Medication and Treatment Administration and Delegation policy dated April 1, 2025, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee will ensure that the registered nurse has: 1. Instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified in writing, specific instructions for each resident and documented those instructions in the resident's record 3. Communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on July 15, 2025, to mitigate immediate risk to residents; however, the scope and level remains at I. RESIDENT SPECIFIC INSTRUCTIONS R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes. On July 15, 2025, at 9:54 a.m., the surveyor observed ULP-E administered medications to R1. R1's service plan dated June 28, 2025, indicated R1 received services to include medication management, and medication administration.	01750			

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01750	Continued From page 47 R1's medication administration record (MAR) dated July 2025, included: -metolazone 2.5 milligrams (mg); take one tablet by mouth once daily as needed for lower leg swelling. R1's record did not include instructions regarding how much lower leg swelling was considered enough swelling to administer the metolazone. R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. On July 17, 2025, at 8:43 a.m., the surveyor observed ULP-E administer medications to R2. R2's service plan dated June 24, 2025, indicated R2 received services to include medication management, and medication administration. R2's MAR dated July 2025, included the following: -polyethylene glycol powder 17 grams (g); Mix one capful (17 g) in liquid and take by mouth once daily as needed for constipation -senna-S 8.6-50 mg; take two tablets by mouth once a day as needed for constipation -milk of magnesia; 30 milliliters (ml); by mouth as needed for mild constipation -glycerin suppository; one suppository as needed for moderate constipation -fleets enema as needed for moderate-severe constipation, contact nursing before giving R2's record did not include instructions for the ULP to understand which PRN medication for constipation should be given in which order. R3	01750			

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01750	Continued From page 48 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). On July 15, 2025, at 7:40 a.m., the surveyor observed ULP-F administer medications to R3. R3's service plan dated July 14, 2025, indicated R3 received services to include medication management and medication administration. PAIN R3's MAR dated July 2025, included the following as needed (PRN) medications for pain: -acetaminophen 500 mg; take two tablets by mouth every six hours as needed -Tylenol 325 mg; take two tablets by mouth every hour hours as needed R3's record did not include instructions for the ULP to understand which PRN pain medication should be given in which order. CONSTIPATION R3's MAR dated July 2025, included the following PRN medications for constipation: -adult glycerin suppository; unwrap and insert one rectally daily as needed -bisacodyl 10 mg suppository; unwrap and insert one suppository rectally twice daily once a week as needed -docusate 100 mg; take one capsule by mouth twice daily as needed -fiber lax 625 mg; take one tablet by mouth once daily as needed -fleets enema; use one enema rectally daily as needed -glycerin 2 grams (gm); unwrap and insert one suppository rectally once daily as needed	01750			

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01750	Continued From page 49 -milk of magnesia suspension; give 30 ml daily orally as needed -polyethylene glycol; may increase to one capful (17 g) as tolerated -senna 8.6 mg; take two tablets by mouth daily as needed -milk of magnesia 30 ml by mouth as needed for mild constipation -glycerin suppository; one suppository every day as needed for moderate constipation -fleets enema as needed for moderate -severe constipation -stool soften c100 mg; one capsule orally two times daily as needed R3's record did not include instructions for the ULP to understand which PRN medication for constipation should be given in which order. ANTACID R3's MAR dated July 2025, included the following PRN medications for heartburn: -antacid 200 mg; chew one tablet orally four times daily as needed -calcium antacid 500 mg; take one tablet by mouth four times daily as needed -SM Antacid chewable 500 mg; chew one tablet orally four times daily as needed R3's record did not include instructions for the ULP to understand which PRN medication for heartburn should be given in which order. CHEST CONGESTION/COUGH R3's MAR dated July 2025, included the following PRN medications for congestion/cough: -chest congestion DM 100-10 mg/5 ml; take 5 ml by mouth every four hours as needed -guaiaisorb DM liquid; take 10 ml every four hours as needed	01750			

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01750	Continued From page 50 -pseudoephedrine 30 mg; take one tablet by mouth every six hours as needed -SM Tussin DM 100-10/5; give 5-10 ml orally every four hours as needed -Robitussin or generic substitute; 5 ml by mouth every four hours as needed for mild cough/congestion -tusnel-ex 100 mg/5 ml; give 5 ml by mouth every four hours as needed R3's record did not include instructions for the ULP to understand which PRN medication for chest congestion and cough should be given in which order. ANXIETY R3's MAR dated July 2025, included the following PRN medications for anxiety: -clonazepam 0.25 mg; take one tablet by mouth twice daily as needed -hydroxyzine 25 mg; take one tablet by mouth every six hours as needed R3's record did not include instructions for the ULP to understand which PRN medication for anxiety should be given in which order. On July 16, 2025, at 11:58 a.m., CNS-C stated R1, R2, and R3's medications listed above did not include resident specific instructions for the ULP. The licensee's Medication and Treatment-Administration and Delegation policy dated April 1, 2025, indicated a order must specify, in writing, specific instructions for each resident ad document those instructions in the resident's record. No further information was provided.	01750			

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01750	Continued From page 51	01750			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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 observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber's orders for one of two residents (R1) and failed to ensure medication administration was documented accurately for one of three residents (R3). 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).	01760			

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NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE		STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077			
(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
01760	Continued From page 52 The findings include: R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes. On July 15, 2025, at 9:54 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1. R1's service plan dated June 28, 2025, indicated R1 received services to include medication management, and medication administration. R1's prescriber order dated June 5, 2025, included: -polyethylene glycol 17 grams (g); mix one scoop (17 g) in liquid then take by mouth once daily if needed for constipation R1's medication administration record (MAR) dated July 2025, did not include polyethylene glycol. On July 16, 2025, at 12:07 p.m., clinical nurse supervisor (CNS)-C reviewed R1's MAR and stated the polyethylene glycol order was not listed. CNS-C stated R1's bowel medications were put on hold until after her colonoscopy and the polyethylene glycol must not have been re-started. R3 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). R3's service plan dated July 14, 2025, indicated	01760			

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01760	Continued From page 53 R3 received services to include medication management and medication administration. On July 15, 2025, at 7:40 a.m., the surveyor observed ULP-F prepare R3's medications and bring them to her room to administer. ULP-F went to R3's side table in her bedroom and opened a bottle of apple cider vinegar, removed one tablet and placed it in the medication cup with R3's other medications. ULP-F administered the medications to R3. They surveyor inquired about the apple cider vinegar tablet and R3 stated the staff administered it to her for weight loss. ULP-F stated every morning the ULP would remove one tablet from the bottle and add it to the rest of R3's medications. R3's record lacked prescriber orders for apple cider vinegar tablets. R3's MAR dated July 2025, did not include the apple cider vinegar tablets. R3's record lacked documentation of medication administration of the apple cider vinegar tablets. On July 16, 2025, at 11:51 a.m., CNS-C stated the nurses were not aware that R3 kept any medications in her bedroom and that staff administered them to R3. CNS-C stated R3's record would not have documentation of the apple cider vinegar tablets being administered as they did not have an order for it. The licensee's Medication and Treatment Record-Documentation and Refusal policy dated April 1, 2025, indicated the licensee would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration	01760			

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01760	Continued From page 54 and or treatments and therapies. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (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 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: During the entrance conference on July 14, 2025, at approximately 9:20 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to their	01770			

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01770	Continued From page 55 residents, including medication set up. CNS-C stated R6 had a medication machine that the nurse's setup medications. R6 was admitted on May 23, 2017, with diagnoses that included schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly). R6's service plan dated June 27, 2025, indicated R6 received services to include medication management. R6's signed prescriber orders dated July 17, 2025, included the following medications: -atorvastatin 10 milligrams (mg); take one tablet by mouth once a day (cholesterol) -Jardiance 10 mg; take one tablet by mouth daily (diabetes) -Risperdal 1 mg; take one tablet by mouth daily (schizophrenia) -Vitamin D2 1.25 mg; take one capsule by mouth once a week (supplement) -Xarelto 10 mg; take one tablet by mouth daily (blood thinner) R6's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On July 14, 2025, at 2:24 p.m., regional registered nurse (RRN)-H and CNS-C stated R6's record lacked documentation of medication setup to include the required content. RRN-H and CNS-C stated they were not aware of the documentation requirement for medication setup. The licensee's Medication Management-Administration and Setup policy	01770			

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01770	Continued From page 56 dated April 1, 2025, indicated documentation of medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin pens had a pharmacy label for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 was admitted on April 15, 2025, with	01890			

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01890	Continued From page 57 diagnoses that included diabetes. R1's service plan dated June 28, 2025, indicated R1 received services to include diabetic management, medication management, and medication administration. R1's signed prescriber orders dated June 17, 2025, included: -Novolog Flexpen 100 units/milliliter; Inject 10 units subcutaneously twice daily with lunch and dinner meals (diabetes) On July 14, 2025, at 11:58 a.m., the surveyor observed unlicensed personnel (ULP)-E remove a Novolog insulin pen from a small bin in the medication cart with R1's name on it. ULP-E stated all residents with insulin had a separate bin in the medication cart that stored their insulin. ULP-E prepared R1's insulin as prescribed. The insulin pen had an open date written on it; however, it did not have a pharmacy label on it. On July 16, 2025, at 11:36 a.m., clinical nurse supervisor (CNS)-C stated she was unsure of why R1's Novolog insulin pen did not have a pharmacy label on it as the individual pens typically did have a pharmacy label on them. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910			

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01910	Continued From page 58 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (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 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: R5 was admitted to the licensee on March 1, 2024, and discharged on June 2, 2025.	01910			

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01910	Continued From page 59 R5's discharge summary dated June 2, 2025, indicated R5 received assistance with medication management and medications were destroyed per facility protocol (disposition form attached). R5's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On July 14, 2025, at 2:01 p.m., regional registered nurse (RRN)-H stated R5's disposition of medications from when he discharged could not be located. The licensee's Medication Disposal policy dated April 1, 2025, indicated upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940			

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01940	Continued From page 60 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 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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1 and 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	01940			

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01940	Continued From page 61 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: R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes. On July 15, 2025, at 9:54 a.m., the surveyor observed unlicensed personnel (ULP)-E check R1's blood sugar and blood pressure. R1's service plan dated June 28, 2025, indicated R1 received services to diabetic management, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties), and oxygen. R1's medication administration record (MAR) dated July 2025, included the following treatments: -Blood Glucose monitoring twice a day -Blood pressure check daily -Freestyle Libre Sensor; continuous glucose sensor; apply and change sensor every 14 days R1's service checkoff list dated July 2025, include the following treatments: -BIPAP; put on at night and turn off in the morning -Oxygen 2 L (liters) per nasal cannula R1's prescriber orders dated May 19, 2025, included: -Blood glucose checks twice a day -Oxygen 2 L continuously per nasal cannula	01940			

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01940	Continued From page 62 -Freestyle Libre sensor; change every 14 days R1's record lacked prescriber orders for daily blood pressure checks and BIPAP. R1's individualized treatment or therapy management plan dated June 17, 2025, indicated R1 received treatments to include blood sugar checks, Freestyle Libre sensor and BIPAP. R1's treatment plan failed to include the following required content: -a statement of the type of services that will be provided (daily blood pressure checks, oxygen) R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. On July 15, 2025, at 8:43 a.m., the surveyor observed ULP-E check R2's blood sugar and administer medications. R2's service plan dated June 24, 2025, indicated R2 received services to include comprecare (type of compression stocking to reduce swelling in legs), blood glucose monitoring, and diabetic management. R2's service plan did not include weekly weights, BIPAP or Libre sensor changes. R2's MAR dated July 2025, included the following treatments: -Blood Glucose monitoring three times a day -BIPAP: off at 8:00 a.m., and on at 10:00 p.m. -Freestyle Libre Reader, continuous blood receiver -Weekly Weights; weight resident weekly on	01940			

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01940	Continued From page 63 Wednesday morning. Notify nursing with >3 pounds. R2's service checkoff list dated July 2025, included the following treatments: -comprecares R2's prescriber orders included: -BIPAP, order dated March 14, 2025 -Blood glucose checks three times a day, order dated July 14, 2025 -Comprecares, order dated March 26, 2024 -Freestyle Libre sensor; change every 14 days, order dated July 14, 2025 -Weekly weights, order dated July 14, 2025 R2's individualized treatment or therapy management plan dated June 25, 2025, indicated R2 received treatments to include blood sugar checks, comprecares and BIPAP. R2's treatment plan failed to include the following required content: -a statement of the type of services that will be provided (weekly weights, freestyle Libre sensor) On July 16, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-C and registered nurse (RN)-D reviewed R1 and R2's individualized treatment plans and stated they lacked the required content as listed above. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2025, indicated a current individualized treatment and therapy management record for each resident would contain the following: -a statement of the type of services that would be provided -documentation of specific resident instructions	01940			

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01940	Continued From page 64 relating to the treatments or therapy administration -identification of treatment or therapy tasks that would be delegated to unlicensed personnel -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications on adverse reactions The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950			

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01950	Continued From page 65 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP) had been competency tested by a licensed registered nurse (RN) prior to administering treatments. 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 July 14, 2025, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment management services to the licensee's residents. Licensed assisted living director (LALD)-A and assistant manager (AM)-B stated when a new ULP was hired, they were scheduled for a minimum of three days on the floor training. On day one, the new ULP would shadow and observe the trainer provide services, including treatments, to the residents. On day two, the new ULP starts to assist the trainer with administering treatments. On day three, the new ULP	01950			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE			STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077		
(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
01950	Continued From page 66 completes all the resident services including treatments while the trainer shadows and observes them. After the ULP have completed the three days of training, the nurse will meet with them to competency test them on delegated tasks, treatments, and medication management tasks. On July 15, 2025, at 6:53 a.m., ULP-G stated she was hired in May of 2025, as a caregiver and a medication passer. The surveyor inquired how she was trained on medication and treatment management services. ULP-G stated she had to complete several Educare (training software) courses before she could do any training on the floor. Once she completed Educare, she had three days of training on the medication cart. ULP-G stated on the first day, she watched the trainer complete all the medication and treatment tasks. On the second day, she set up and administered some of the resident's medications and treatments with the oversight of the trainer. On the third day, ULP-G stated she completed all medication and treatment management tasks assigned to her while the trainer was around and available to assist if needed. ULP-G stated after the three days of training, she was asked if she was comfortable with passing medications or if she needed more training dates. ULP-G stated she was comfortable and was scheduled to meet with the nurse to be competency tested a few days later. On July 15, 2025, at 11:20 a.m., the surveyor met with regional nurse (RN)-H, clinical nurse supervisor (CNS)-C, LALD-A, and AM-B to review the licensee's procedure for ULP competency testing on medication and treatment management services. AM-B stated new ULP are scheduled to train for three days. On day one, the new ULP	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE			STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077		
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01950	Continued From page 67 observed the trainer complete all medication and treatment management tasks. On day two, the new ULP would administer medications, check blood sugars and administer insulin to some of the residents while the trainer completed most of the medication and treatment management tasks. On day three, the new ULP would administer all medication tasks (oral medications, insulin, topicals, etc.) and complete resident treatments (blood sugar checks, etc.) for all residents and could utilize the trainer as needed. After the third day of training, if the ULP was comfortable with medication and treatment management tasks, then the RN would set up a time for the new ULP to demonstrate competency with medication and treatment management tasks. CNS-C and LALD-A stated this was an accurate explanation of the training process for medication and treatment management tasks. The licensee's Medication and Treatment Administration and Delegation policy dated April 1, 2025, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee will ensure that the registered nurse has: 1. Instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified in writing, specific instructions for each resident and documented those instructions in the resident's record 3. Communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
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01950	Continued From page 68	01950			
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for three of three residents (R1, R2 and R3) receiving treatments. 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 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: R1 R1 was admitted on April 15, 2025, with diagnoses that included diabetes.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
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01970	Continued From page 69 On July 15, 2025, at 9:54 a.m., the surveyor observed unlicensed personnel (ULP)-E check R1's blood sugar and blood pressure. R1's service plan dated June 28, 2025, indicated R1 received services including diabetic management, BIPAP (bilevel positive airway pressure) (non-invasive ventilation used to help people with breathing difficulties), and oxygen. R1's medication administration record (MAR) dated July 2025, included the following treatments: -Blood Glucose monitoring twice a day -Blood pressure check daily -Freestyle Libre Sensor; continuous glucose sensor; apply and change sensor every 14 days R1's service checkoff list dated July 2025, include the following treatments: -BIPAP; put on at night and turn off in the morning -Oxygen 2 L (liters) per nasal cannula R1's prescriber orders dated May 19, 2025, included: -Blood glucose checks twice a day -Oxygen 2 L continuously per nasal cannula -Freestyle Libre sensor; change every 14 days R1's record lacked prescriber orders for daily blood pressure checks and BIPAP. R2 R2 was admitted on April 25, 2023, with diagnoses that included diabetes. On July 15, 2025, at 8:43 a.m., the surveyor observed ULP-E check R2's blood sugar and administer medications.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE			STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077		
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01970	Continued From page 70 R2's service plan dated June 24, 2025, indicated R2 received services to include comprecare (type of compression stocking to reduce swelling in legs), blood glucose monitoring, and diabetic management. R2's service plan did not include weekly weights, BIPAP or Libre sensor changes. R2's MAR dated July 2025, included the following treatments: -Blood Glucose monitoring three times a day -BIPAP: off at 8:00 a.m., and on at 10:00 p.m. -Freestyle Libre Reader, continuous blood receiver -Weekly Weights; weigh resident weekly on Wednesday morning. Notify nursing with >3 pounds. R2's service checkoff list dated July 2025, included the following treatments: -comprecares R2's prescriber orders included: -BIPAP, order dated March 14, 2025 -Blood glucose checks three times a day, order dated July 14, 2025 -Comprecares, order dated March 26, 2024 -Freestyle Libre sensor; change every 14 days, order dated July 14, 2025 -Weekly weights, order dated July 14, 2025 R2's record did not include a current order within the past 12 months for comprecares. R3 R3 was admitted on July 19, 2021, with diagnoses that included quadriplegia (paralysis that affects the ability to voluntarily move the	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30696	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER INVER GROVE HEIGHTS WHITE PINE		STREET ADDRESS, CITY, STATE, ZIP CODE 9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077			
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01970	Continued From page 71 upper and lower body). R3's service plan dated July 14, 2025, indicated R3 received services to include range of motion (ROM), brace application/removal and wound care. R3's service checkoff list dated July 2025, included the following treatments: -Brace Application/Removal: apply braces to both feet every night before bed. Take off each morning. -Range of Motion: Follow physical therapy/occupational therapy approved ROM, instructions in apartment for stretching legs. See delegated task book for specific instructions with pictures. -Wound care; cleanse wound, apply house stock barrier cream cover with dressing three times a week R3's prescriber orders included: -wound care three times a week, order dated February 18, 2025 -seated lower extremity exercises x 10 reps moderate to maximum assistance for rage of motion (pictures issued), order dated May 5, 2022 -heel protector bilaterally, order dated July 15, 2025. R3's record did not include a current order within the past 12 months for range of motion exercises. R3's record contained an order for heel protectors dated July 15, 2025; however, this was requested and received after the start of the survey. On July 16, 2025, at 12:22 p.m., clinical nurse supervisor (CNS)-C stated R1, R2, and R3's record lacked up to date prescriber orders as indicated above.	01970			

Minnesota Department of Health

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01970	Continued From page 72 The licensee's Medication and Treatment Orders policy dated April 1, 2025, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Inver Grove Heights WP LLC
9056 Buchanan Trl
Inver Grove Heights, MN 55076
Dakota County
Parcel:

Phone:

License Info

License: HFID 30696

Risk:
License:
Expires on:
CFPM: RAVIN NARASAN
CFPM #: 57903; Exp: 4/9/2028

Inspection Info

Report Number: F1036251043
Inspection Type: Full - Single
Date: 7/15/2025 Time: 12:30:52 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: DISH MACHINE WAS NOT ABLE TO REACH REQUIRED UST OF 160 DEGREES F. ADVISED TO USE 3 COMP SINK UNTIL UNIT CAN BE SERVICED.

Comply By: 7/22/2025 Originally Issued On: 7/15/2025

New Order: 6-100 Physical Facility Construction Materials

6-101.11A1 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

COMMENT: THE FRP IS MISSING OFF THE WALL BY THE 3 COMP SINK. REPLACE AND MAINTAIN.

Comply By: 7/29/2025 Originally Issued On: 7/15/2025

New Order: 6-200 Physical Facility Design and Construction

6-202.11A *Priority Level: Priority 3 CFP#: 56*

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

COMMENT: OBSERVED A DAMAGED LIGHT SHIELD IN THE KITCHEN DRY STORAGE AREA. REPLACE AND MAINTAIN.

Comply By: 7/29/2025 Originally Issued On: 7/15/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS KASSIE MARKING. INSPECTION CONDUCTED IN PRESENCE OF RAVIN NARASAN, THE PERSON IN CHARGE.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.

-
- THERMOMETER USE AND CALIBRATION.
 - DATE MARKING.
 - PEST CONTROL.
 - FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.

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

****IF ANY RESIDENT COMPLAINS 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: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1036251043 from 7/15/2025



RAVIN NARASAN
KITCHEN MANAGER

Jeff Johanson,
Public Health Sanitarian 1
651-201-4349
jeff.johanson@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Inver Grove Heights WP LLC
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1036251043
Inspection Type: Full
Date: 7/15/2025
Time: 12:30:52 PM

Equipment Temperature: Product/Item/Unit: AURORA DOUBLE DOOR COOLER; **Temperature Process:** Ambient Air
Location: KITCHEN at 32 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AURORA DOUBLE DOOR FREEZER; **Temperature Process:** Ambient Air
Location: KITCHEN at -5 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ATOSA DOUBLE DOOR COOLER; **Temperature Process:** Ambient Air
Location: BASEMENT at 35 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ATOSA DOUBLE DOOR FREEZER; **Temperature Process:** Ambient Air
Location: BASEMENT at -8 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Inver Grove Heights WP LLC
Inver Grove Heights
County/Group: Dakota County

Inspection Info

Report Number: F1036251043
Inspection Type: Full
Date: 7/15/2025
Time: 12:30:52 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: KITCHEN Equal To 142 Degrees F.

Comment: ATTEMPTED DISH MACHINE SEVERAL TIMES AND WAS NEVER ABLE TO REACH REQUIRED SANITIZING
UST OF 160. ADVISED TO USE 3-COMP SINK UNTIL UNIT IS SANITIZING PROPELY.

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** 3-Compartment Sink

Location: KITCHEN Equal To 300 PPM

Comment:

Violation Issued?: No