



Protecting, Maintaining and Improving the Health of All Minnesotans

March 22, 2022

Administrator
Inver Grove Heights White Pine
9056 Buchanan Trail
Inver Grove Heights, MN 55077

RE: Project Number(s) SL30696015

Dear Administrator:

On March 10, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 3, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonthan Hill', written over a light gray circular background.

Jonthan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 5, 2022

Administrator
Inver Grove Heights White Pine
9056 Buchanan Trail
Inver Grove Heights, MN 55077

RE: Project Number(s) SL30696015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 3, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Inver Grove Heights White Pine

January 5, 2022

Page 3

85 East Seventh Place
St. Paul, MN 55164-0970

85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

A handwritten signature in dark ink, appearing to read "Jonathan Hill", is written over a light gray rectangular background.

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

pmb

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 12/03/2021
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 Initial comments *****ATTENTION***** ASSISTED LIVING 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: SL30696015 On November 30 through December 2, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were fifty-two (52) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

Minnesota Department of Health

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

TITLE

(X6) DATE

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 12/03/2021
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
0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 430		

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 12/03/2021
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
0 430	Continued From page 2 The findings include: The facility converted to an Assisted Living license on August 1, 2021. R1, R2, R3, and R4's record lacked evidence of a signature from the resident or resident's representative indicating that a UDALSA was provided, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and -an oral explanation of the services offered under the contract. R1 R1 was admitted June 30, 2021. R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record did not include documentation of receipt of the UDALSA. R2 R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with	0 430		

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 12/03/2021
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
0 430	Continued From page 3 medication administration, bathing, housekeeping and laundry. R2's Acknowledgements form, dated October 25, 2021, included a UDALSA acknowledgement of receipt, but the form was incomplete with no signature of the resident or the resident's representative. On December 1, 2021, at 2:54 p.m., licensed assisted living director (LALD)-B verified R2's acknowledgement form lacked a signature of the resident or resident's representative. LALD-B stated it was difficult to get the resident's representative to sign the documents. R3 R3 was admitted February 19, 2018. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose monitoring, housekeeping and laundry. R3's record did not include documentation of receipt of the UDALSA. R4 R4 was admitted July 22, 2019. R4's service plan, dated January 15, 2021, indicated R4 received services for assistance with medication administration, bathing, dressing, grooming, housekeeping and laundry. R4's record did not include documentation of receipt of the UDALSA.	0 430		

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 12/03/2021
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
0 430	Continued From page 4 On December 1, 2021, during a 1:58 p.m. interview, LALD-B stated new residents are given the UDALSA, but could not confirm all previous residents had been given the UDALSA. The licensee's Uniform Disclosure of Assisted Living Services and Amenities policy, dated August 1, 2021, indicated "[licensee] will provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an Assisted Living contract." The policy further indicated, "The facility will obtain written acknowledgement from the resident or resident representative that [licensee] provided the UDALSA or document the reason why an acknowledgement was not obtained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;	0 450		

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 12/03/2021
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
0 450	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide current Minnesota Assisted Living Bill of Rights (BOR) for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility converted to an Assisted Living license on August 1, 2021. R1, R2, R3, and R4's records lacked evidence of a signature from the resident or resident's representative indicating that the current Assisted Living BOR was provided. R1 R1 was admitted June 30, 2021. R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record included an Acknowledgements form, dated June 30, 2021, to include	0 450		

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 12/03/2021
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	
0 450	Continued From page 6 acknowledgement of receipt of "The Home Care Bill of Rights", but did not include documentation of receipt of the current Assisted Living BOR. On December 2, 2021, at 10:45 a.m., licensed assisted living director (LALD)-B provided documentation of receipt of the current Assisted Living BOR signed by R1's representative on December 1, 2021, during the survey. R2 R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry. R2's record included an Acknowledgements form, dated October 25, 2021, to include acknowledgement of receipt of the current assisted living BOR, but the form was not completed and lacked a signature of the resident or the resident's representative. On December 1, 2021, at 2:54 p.m., LALD-B verified R2's acknowledgement form lacked a signature of the resident or resident's representative. LALD-B stated it was difficult to get the resident's representative to sign the documents. R3 R3 was admitted February 19, 2018. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose	0 450			

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 12/03/2021
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
0 450	Continued From page 7 monitoring, housekeeping and laundry. R3's record included an Acknowledgements form, dated July 8, 2020, indicating acknowledgement receipt of "The Home Care Bill of Rights", but did not include documentation of receipt of the current Assisted Living BOR. R4 R4 was admitted July 22, 2019. R4's service plan, dated January 15, 2021, indicated R4 received services for assistance with medication administration, bathing, dressing, grooming, housekeeping and laundry. R4's record included an Acknowledgements form, dated July 22, 2019, to include acknowledgement of receipt of "The Home Care Bill of Rights", but did not include documentation of receipt of the current Assisted Living BOR. On December 1, 2021, 2:40 p.m., registered nurse (RN)-A provided the new resident admission packet which included the current Assisted Living BOR. On December 2, 2021, during a 10:45 a.m. interview, LALD-B verified R1, R2, R3, and R4's records did not include documentation of receiving the current Assisted Living BOR prior to the survey. LALD-B further indicated the current BOR was likely sent out to residents by the previous management, but was unable to provide documentation. The licensee's Bill of Rights policy, dated August 1, 2021, indicated "[licensee] will provide each resident with the Assisted Living Care Bill of	0 450		

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 12/03/2021
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	
0 450	Continued From page 8 Rights." The policy further indicated, "[licensee] must obtain written acknowledgement of the resident's receipt of the BOR or shall document why an acknowledgement cannot be obtained. The acknowledgement may be obtained from the resident or the resident's representative." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470			

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 12/03/2021
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
0 470	Continued From page 9 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all fifty-two (52) 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) 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 November 30, 2021, at approximately 10:00 a.m., during the entrance conference, the facility staffing plan was requested from the licensed assisted living director (LALD)-B. On December 2, 2021, at 2:55 p.m., LALD-B acknowledged the licensee does not have a documented staffing plan. LALD-B further stated they discussed staffing-related issues with residents at resident council and during the subsequent staff meeting how staffing needs can be adjusted to better serve residents. The licensee's Staffing & Scheduling policy, dated August 1, 2021, indicated, "The clinical nurse supervisor/RN will develop and implement a written staffing plan that provides an adequate	0 470		

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 12/03/2021
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
0 470	Continued From page 10 number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all fifty-two (52) residents. This practice resulted in a level two violation (a	0 480		

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 12/03/2021
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
0 480	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated November 30, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program	0 510		

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 12/03/2021
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
0 510	Continued From page 12 that complied with accepted health care, medical and nursing standards for infection control related to COVID-19 per the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines. This had the potential to affect all fifty-two (52) residents, visitors and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings Include: The licensee failed to ensure staff performed hand hygiene (HH) according to the CDC and MDH guidelines during medication administration for two of four residents (R4, R6) observed for medication administration. The CDC document titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 10, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds. R4 was admitted July 22, 2019, and had	0 510		

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 12/03/2021
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
0 510	Continued From page 13 diagnoses to include diabetes mellitus. R6 was admitted November 22, 2021, and had diagnoses to include diabetes mellitus and chronic kidney disease. During a medication administration observation on December 1, 2021, at 11:00 a.m., unlicensed personnel (ULP)-D performed hand hygiene (HH), donned gloves, and gathered medications for R2 and medication and treatment supplies for R4. ULP-D entered R2's room, administered medications to R2, and doffed gloves. ULP-D did not perform HH before entering R4's room, donned gloves, and proceeded to check R4's blood glucose level. ULP-D then administered an insulin injection via insulin pen. ULP-D doffed gloves, gathered supplies and returned to the medication cart. No HH was observed. ULP-D accessed the medication cart, gathered medications for R6, documented the narcotic medication count in the narcotic book, donned gloves, and proceeded in the elevator to the 3rd floor to R6's room. ULP-D administered medications to R6, doffed gloves, exited room and walked down stairs to the medication cart. ULP-D was observed to then perform HH with alcohol-based hand sanitizer. On December 1, 2021, at approximately 11:13 a.m., ULP-D stated she did not carry hand sanitizer, but some residents had it in their rooms. ULP-D verbalized she should perform HH after taking gloves off. ULP-D further stated she did not perform HH between residents during the observation, but did change gloves. On December 2, 2021, at 2:07 p.m., registered nurse (RN)-A verified staff would be expected to perform HH after doffing gloves and between	0 510		

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 12/03/2021
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
0 510	Continued From page 14 residents. RN-A acknowledged HH would need improvement. The licensee's Hand Washing policy, dated August 1, 2021, indicated, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." The licensee's Infection Control policy, dated August 1, 2021, indicated, "[licensee's] infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in Assisted Living facilities." TIME PERIOD TO CORRECT: Seven (7) Days	0 510		
0 630 SS=D	144G.42 Subd. 6 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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include	0 630		

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 12/03/2021
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
0 630	Continued From page 15 all required content for two of four residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted June 30, 2021. R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record included a vulnerability assessment dated June 30, 2021, that identified vulnerabilities to include speech and language barriers, history of falls, and inability to report concerns of abuse. R1's record lacked an IAPP to include 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. R2 R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021,	0 630		

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 12/03/2021
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
0 630	Continued From page 16 indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry. R2's record included a vulnerability assessment dated October 29, 2021, that identified vulnerabilities to include chronic pain, history of falls, and mild cognitive decline. R2's record lacked an IAPP to include 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. On December 2, 2021, at 2:07 p.m., registered nurse (RN)-A indicated the vulnerability assessment for R1 and R2 were intended to serve as the IAPP. RN-A acknowledged the IAPP for R1 and R2 lacked required content. The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated, "[licensee] will develop and implement an individual abuse prevention plan for each vulnerable adult." The policy further indicated, "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 the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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 12/03/2021
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
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, baseline testing and screening for 2 of 3 employees (registered nurse (RN)-A, unlicensed personnel (ULP)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 660		

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 12/03/2021
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
0 660	Continued From page 18 The findings include: On November 30, 2021, at 11:09 a.m. during the entrance conference RN-A stated he did not think they completed a TB facility risk assessment, but did screen employees upon hire. RN-A RN-A was hired July 26, 2021, and provided supervisory and nursing assessment services for residents of the facility. RN-A's employee record lacked documentaiton of a TB baseline test and screening. On November 30, 2021, at 1:35 p.m., licensed assisted living director (LALD)-B indicated RN-A's TB screening was in the employee file at another facility location. LALD-B provided RN-A's TB blood test results dated February 24, 2020, which is greater than 90 days prior to RN-A's hire date. RN-A's TB history and symptom screening documentation was requested but not provided. On December 2, 2021, at 12:57 p.m., RN-A verified the TB blood test was from previous employment was greater than 90 days prior to hire. RN-A was not able to state whether the licensee completed a TB history and symptom screening form upon hire. ULP-D ULP-D was hired August 23, 2021, and provided direct cares for residents of the facility. On December 1, 2021, at 11:00 a.m., ULP-D was observed administering medications to residents (R2, R4, R6).	0 660		

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 12/03/2021
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
0 660	Continued From page 19 ULP-D's employee record lacked documentation of a TB baseline test and screening. On December 2, 2021, at 12:57 p.m., RN-A verified ULP-D's TB test results and screening form were not present in ULP-D's employee record. RN-A stated ULP-D had a TB blood test done. Results were requested but not provided. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated, "The facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health." The policy further indicated staff would be educated regarding TB at the time of hire, "New staff will be screened for active signs of TB using the Baseline Screening Tool for HCWs", "New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline Screening Tool for HCWs", and "Staff TB screening results will be kept in each employee medical file".	0 660		

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 12/03/2021
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
0 660	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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 12/03/2021
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
0 730	Continued From page 21 appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1, R2, R3 and R4's medical records lacked documentation of services received. R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with	0 730		

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 12/03/2021
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
0 730	Continued From page 22 medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's service record for November 2021 included, but was not limited to, the following scheduled services: safety checks, transfer (ensure walker is next to resident's bed at hours of sleep), eating, and bathing. R1's service record lacked the following documentation for November 2021: -102 of 120 scheduled services for safety checks; -25 of 30 scheduled services for transfer; -55 of 90 scheduled services for eating; and -8 of 9 scheduled services for bathing. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry. R2's service record for November 2021 included, but was not limited to, the following scheduled services: safety checks, "linen", meals, and bathing. R2's service record lacked the following documentation for November 2021: -119 of 120 scheduled services for safety checks; -4 of 4 scheduled services for "linen"; -52 of 90 scheduled services for meals; and -9 of 9 scheduled services for bathing. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose monitoring, housekeeping and laundry. R3's service record for November 2021 included, but was not limited to, the following scheduled services: "daily tidy," laundry, meals, and safety checks. R3's service record lacked the following documentation for November 2021:	0 730		

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 12/03/2021
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	
0 730	Continued From page 23 -27 of 28 scheduled services for "daily tidy"; -4 of 4 scheduled services for laundry; -42 of 82 scheduled services for meals; and -93 of 112 scheduled services for safety checks. R4's service plan, dated January 15, 2021, indicated R4 received services for assistance with medication administration, bathing, dressing, grooming, housekeeping and laundry. R4's service record for November 2021 included, but was not limited to, the following scheduled services: "daily tidy," personal hygiene routine, laundry, meals, safety checks, bathing, and dressing. R4's service record lacked the following documentation for November 2021: -25 of 28 scheduled services for "daily tidy"; -26 of 28 scheduled services for personal hygiene routine; -4 of 4 scheduled services for laundry; -40 of 84 scheduled services for meals; -27 of 28 scheduled services for safety checks; -4 of 4 scheduled services for bathing; and -27 of 28 scheduled services for dressing. On December 2, 2021, at 9:40 a.m., registered nurse (RN)-A verified caregiver services documentation for R1, R2, R3, and R4 was missing many areas of documentation of cares. The licensee's Resident Record-Documentation policy dated August 1, 2021, indicated, "Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident." The policy further indicated, "When medications, services, treatments, or therapies or (sic) not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered."	0 730			

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 12/03/2021
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
0 730	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 building tour on December 1, 2021, between 10:30 a.m. and 12:15 p.m. with	0 800		

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 12/03/2021
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
0 800	Continued From page 25 maintenance staff (MS)-H, the surveyor observed numerous door closers were disabled or removed from apartment doors. MS-H stated that all residents or family members of residents requested the door closer be removed from the apartment door because the resident cannot open the door without assistance. He also stated that they have had minor injuries to residents due to the door closers aggressively shutting the door while the resident is entering or exiting the apartment. Door closers are an important part of life safety design in the building due to the shelter in place fire policy. Surveyor recommended contacting local fire code official for guidance on door closers. During the building tour on December 1, 2021, between 10:30 a.m. and 12:15 p.m. with MS-H, the surveyor observed batt insulation (fiberglass) inside the HVAC closet in multiple apartments. The fiberglass insulation was located between the sides of the HVAC unit and the closet walls. MS-H stated residents request insulation due to cold air penetration in cold months. Fiberglass insulation could be a hazard to the quality of the indoor air when placed directly against the HVAC unit. Spun-glass fibers could get into the unit or ductwork and be dispersed into the apartment. The insulation observed was blocking the sprinkler head in most of the closets. Sprinklers are an important part of life safety design in the building. Surveyor recommended contacting local fire code official for guidance on acceptable clearances for sprinkler heads in HVAC closets. During the building tour on December 1, 2021, between 10:30 a.m. and 12:15 p.m. with MS-H, the surveyor observed damage to drywall in the mechanical rooms on first and second floor. In second floor mechanical room, drywall tape was	0 800		

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 12/03/2021
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
0 800	Continued From page 26 falling from ceiling and black stains were observed on the ceiling that might be an indication of water damage and mold growth. MS-H confirmed he thought the unit on third floor had frozen at some point and leaked. In first floor mechanical room, drywall was damaged on ceiling and black stains were observed on the ceiling and adjacent wall that might be an indication of water damage and mold growth. Adjacent wall showed signs of recent work. New drywall had been installed, but not taped, mudded, or painted. Orange, rust-like stains were observed above and adjacent to unfinished drywall that might be an indication of a continuous leak or water damage. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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 12/03/2021
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
0 810	Continued From page 27 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of policy, schedule, and log of staff training or resident training for fire safety and evacuation procedures. This had the potential to affect all current 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 December 1, 2021, at approximately 12:15	0 810		

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 12/03/2021
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
0 810	Continued From page 28 p.m., while reviewing emergency preparedness documentation, no evidence was provided for the required twice per year staff training or once per year resident training. Licensed assisted living director (LALD)-B confirmed the licensee had not developed a plan and schedule for required training of staff and residents able to assist in their own evacuation. A policy related to a plan for required training of residents and training of employees was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting	0 900		

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 12/03/2021
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
0 900	Continued From page 29 documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: The facility converted to an Assisted Living license on August 1, 2021.	0 900		

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 12/03/2021
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	
0 900	Continued From page 30 The licensee failed to execute a written assisted living contract with the required content with the resident prior to providing housing or assisted living services. The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of the assisted living contract as required. R1 R1 was admitted June 30, 2021. R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record did not include an assisted living contract. R2 R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry. R2's record included an assisted living contract with required content dated October 29, 2021, but lacked a signature of the resident or the resident's representative. R2's record included an Acknowledgements form dated October 25, 2021, to include acknowledgement of receipt of a "Resident	0 900			

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 12/03/2021
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
0 900	Continued From page 31 Agreement," but the form was not completed and lacked a signature of the resident or the resident's representative. On December 1, 2021, at 2:54 p.m., licensed assisted living director (LALD)-B verified R2's assisted living contract was not signed by the resident or the resident's representative. LALD-B further verified R2's acknowledgement form lacked a signature of the resident or resident's representative. LALD-B stated it was difficult to get the resident's representative to sign the required documents. R3 R3 was admitted February 19, 2018. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose monitoring, housekeeping and laundry. R3's record did not include an assisted living contract. R4 R4 was admitted July 22, 2019. R4's service plan, dated January 15, 2021, indicated R4 received services for assistance with medication administration, bathing, dressing, grooming, housekeeping and laundry. R4's record did not include an assisted living contract. On December 1, 2021, at 1:58 p.m. during an	0 900		

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 12/03/2021
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
0 900	Continued From page 32 interview, LALD-B verified existing residents had not been given the new assisted living contract, but indicated new residents were being provided the new contract upon admission. On December 2, 2021, at 12:26 p.m., LALD-B verified the new assisted living contract was not sent to the regional Ombudsman. LALD-B indicated they would send a copy of the contract to the regional Ombudsman. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated a signed assisted living contract would be received by the facility when a prospective resident decides to move into the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	01440			

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 12/03/2021
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
01440	Continued From page 33 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-D) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired August 23, 2021, and provided direct cares for residents of the facility. On December 1, 2021, at 11:00 a.m., ULP-D was observed administering medications to residents (R2, R4, R6) and performing blood glucose testing for R4. ULP-D's employee record indicated ULP-D was	01440		

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 12/03/2021
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
01440	Continued From page 34 trained on August 5, 2021, in medication administration and treatments, including, but not limited to, blood glucose testing. ULP-D's employee record did not include documentation of direct supervision by an RN within 30 days of ULP-D performing delegated nursing tasks, including medication administration. On December 2, 2021, at 2:07 p.m., RN-A acknowledged ULP-D's 30-day supervision was not documented in the employee record. RN-A indicated he started working at the facility after ULP-D's 30-day supervision was due, so could not confirm whether or not the 30-day supervision occurred. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated, "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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 12/03/2021
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
01470	Continued From page 35 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of 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; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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 12/03/2021
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
01470	Continued From page 36 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for three of three employees (registered nurse (RN)-A, licensed practical nurse (LPN)-C, and unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: RN-A was hired July 26, 2021, and provided supervisory and nursing assessment services for residents of the facility. RN-A's employee record lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144.G; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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 12/03/2021
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
01470	Continued From page 37 Facility Complaints; -Provider's scope of license and types of assisted living services the employee will provide; and -Review of the principles of person-centered planning and service delivery. LPN-C was hired October 12, 2017, and provided direct care services to the residents of the facility. LPN-C's employee record lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144G; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Provider's scope of license and types of assisted living services the employee will provide; and -Review of the principles of person-centered planning and service delivery. ULP-D was hired August 23, 2021, and provided direct cares for residents of the facility. On December 1, 2021, at 11:00 a.m., ULP-D was observed administering medications to residents (R2, R4, R6). ULP-D's employee record lacked documentation the following orientation topics were completed: -Review of the principles of person-centered planning and service delivery. On December 2, 2021, at 2:07 p.m., RN-A acknowledged orientation updates for employees needed improvement. RN-A stated he personally reviewed the assisted living statutes, but did not document that in his employee record. The licensee's Orientation of Staff and	01470		

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 12/03/2021
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
01470	Continued From page 38 Supervisors & Content policy dated August 1, 2021, indicated, All [licensee] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents." The policy further detailed the orientation must include: -An overview of the appropriate Assisted Living statutes and rules -An introduction and review of the facilities' 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 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 and 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 Health Facility Complaints -Consumer advocacy services of 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 -The staff person's job description upon hire and	01470		

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 12/03/2021
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
01470	Continued From page 39 whenever there is a change to the job description that changes the nature of the job or how the job is to be performed -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	01620			

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 12/03/2021
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
01620	Continued From page 40 (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of four residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 June 30, 2021, and had diagnoses to include chronic kidney disease and hypertension (high blood pressure). R1's service plan, dated August 5, 2021, indicated R1 received services for assistance with medication administration, bathing, assistance with activities of daily living (ADLs), dressing and grooming, transfers, and toileting assistance. R1's record included documentation of a	01620		

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 12/03/2021
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
01620	Continued From page 41 comprehensive nursing assessment completed June 30, 2021. No further assessments were documented in R1's record. On December 2, 2021, at 9:40 a.m., RN-A verified R1's 90-day assessment was overdue. RN-A provided a comprehensive assessment for R1 completed December 1, 2021, during the survey. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated, "Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	01650		

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 12/03/2021
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
01650	Continued From page 42 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for two of four residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry.	01650		

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 12/03/2021
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
01650	Continued From page 43 R2's service plan lacked the following: -fees for services -the schedule and methods of monitoring assessments of the resident; -the methods of monitoring staff providing services; and -a contingency plan including identification of and information as to who has authority to sign for the resident in an emergency -information indicating if resident had a health care directive and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. During observation on December 1, 2021, at 11:00 a.m., unlicensed personnel (ULP)-D administered medications to R2. R3 was admitted February 19, 2018. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose monitoring, housekeeping and laundry. R3's service plan lacked the following: -the methods of monitoring assessments of the resident; -the methods of monitoring staff providing services; -a contingency plan including identification of and information as to who has authority to sign for the resident in an emergency -information indicating if resident had a health care directive and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and	01650		

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 12/03/2021
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
01650	Continued From page 44 145C, and declarations made by the resident under those chapters. On December 1, 2021, at 11:22 a.m., licensed practical nurse (LPN)-C was observed administering medications to R3. On December 2, 2021, at 2:07 p.m., registered nurse (RN)-A acknowledged the service plans for R2 and R3 were missing some content. RN-A stated the licensee is trying to get an updated electronic version with all items included. The licensee's Service Plan policy dated August 1, 2021, indicated, "The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident or resident's representative, documenting agreement on the services to be provided. The policy further indicated, "A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions White Pine/Gracewood Senior Living will take if scheduled services cannot be provided ii. Information regarding how the resident can	01650		

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 12/03/2021
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
01650	Continued From page 45 contact [licensee] iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current 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;	01730		

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 12/03/2021
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
01730	Continued From page 46 (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 and maintain a current individualized medication management record for each resident to include all required content for three of four residents (R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has	01730		

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 12/03/2021
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
01730	Continued From page 47 occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted October 29, 2021. R2's service plan, dated October 29, 2021, indicated R2 received services for assistance with medication administration, bathing, housekeeping and laundry. On December 1, 2021, at 11:00 a.m., unlicensed personnel (ULP)-D was observed administering medications to R2. R2's record did not include an individualized medication management plan. R3 was admitted February 19, 2018. R3's service plan, dated July 29, 2021, indicated R3 received services for assistance with medication management, blood glucose monitoring, housekeeping and laundry. R3's service plan included a medication management plan that lacked the following: -documentation of specific resident instructions relating to the administration of medications; and -any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On December 1, 2021, at 11:22 a.m., licensed practical nurse (LPN)-C was observed administering medications to R3.	01730		

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 12/03/2021
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
01730	Continued From page 48 R4 was admitted July 22, 2019. R4's service plan, dated January 15, 2021, indicated R4 received services for assistance with medication administration, bathing, dressing, grooming, housekeeping and laundry. R4's service plan included a medication management plan that lacked the following: -documentation of specific resident instructions relating to the administration of medications; and -any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On December 1, 2021, at 11:09 a.m., unlicensed personnel (ULP)-D was observed administering medications to R4. On December 2, 2021, at 2:07 p.m., registered nurse (RN)-A acknowledged no medication management plan was present in R2's record. RN-A further acknowledged R3 and R4's medication management plans were missing required content. RN-A stated the previous documentation system produced better medication management plans. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated, "[licensee] will 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	01730		

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 12/03/2021
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
01730	Continued From page 49 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 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			

Type: Full
Date: 11/30/21
Time: 11:30:31
Report: 8075211281

Food and Beverage Establishment Inspection Report

Page 1

Location:

Inver Grove Heights White Pine
9056 Buchanan Trail
Inver Grove Heights, MN55077
Dakota County, 19

Establishment Info:

ID #: 0038827
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513069886
ID #:

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

The following orders were issued during this inspection.

5-400 Sewage

5-402.11A

**** Priority 1 ****

MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.

No air gap between ice machine drain line and floor drain.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

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

No irreversible registering temperature indicator onsite for use with kitchen dish machine.

Comply By: 01/31/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

State certified food protection manager's certificate expired on 2/1/21.

Comply By: 01/31/22

Surface and Equipment Sanitizers

Type: Full
Date: 11/30/21
Time: 11:30:31
Report: 8075211281
Inver Grove Heights White Pine

Food and Beverage Establishment Inspection Report

Page 2

Quaternary Ammonium: = 400ppm at Degrees Fahrenheit
Location: sanitizer dispenser
Violation Issued: No

Wash Temp: = at 170 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Rinse Temp: = at 180 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Utensil Surface Temp: = at 166 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 146 Degrees Fahrenheit - Location: hot holding unit - chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 140 Degrees Fahrenheit - Location: hot holding unit - potatoes
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: cooler - turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: cooler - hamburgers
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cooler - cheese
Violation Issued: No

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

Type: Full
Date: 11/30/21
Time: 11:30:31
Report: 8075211281
Inver Grove Heights White Pine

Food and Beverage Establishment Inspection Report

Page 3

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 8075211281 of 11/30/21.

Certified Food Protection Manager: Linda Forschen

Certification Number: FM92589 Expires: 02/01/21

Signed: _____

Ranya Abueid
House Manager

Signed: Erin Tibbetts

Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us