DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 21, 2023

Licensee
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN 55110

RE: Project Number(s) SL30557015

Dear Licensee:

On January 20, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 28, 2022, evaluation were corrected. This 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,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

Electronically delivered

December 28, 2022

Licensee
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN 55110

RE: Project Number(s) SL30557015

Dear Licensee:

On November 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 29, 2022. This follow-up evaluation determined your facility had corrected all of the state licensing orders issued pursuant to the September 28, 2022 evaluation.

At the time of this follow-up evaluation completed on November 29, 2022, we identified the following new violation(s):

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) = $3,000

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-201-3789.

Please note, 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.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30557	A. BUILDING: _____ B. WING _____	R 11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	**1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL30557015-1 On November 29, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 28, 2022. At the time of the survey, there were 40 active residents receiving services under the Assisted Living license. On November 29, 2022 an immediate correction order was reissued at 2310.	0 000		
{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	{0 470}		

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{0 470}	Continued From page 1 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required	{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:	{0 480}		

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{0 480}	Continued From page 2 (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: No further action required	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	{0 680}		

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{0 680}	Continued From page 3 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required	{0 680}		
{0 730} SS=D	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	{0 730}		

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{0 730}	Continued From page 4 resident and actions taken in response to the needs of the resident, including reporting to the 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: No further action required	{0 730}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	{0 780}		

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{0 780}	Continued From page 5 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required	{0 780}		
{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: No further action required	{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;	{0 810}		

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{0 810}	Continued From page 6 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}		

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{0 970}	Continued From page 7 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required	{0 970}		
{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 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: No further action required	{01440}		

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{01880}	Continued From page 8	{01880}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required	{01880}		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of correction for an immediate order issued on September 26, 2022, when no documentation was provided prior to 2:15 p.m., on November 29, 2022, the deadline set after the licensee failed to provide documentation. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	02310		

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02310	Continued From page 9 portion or all of the residents). The findings include: On November 29th, 2022, at 8:59 a.m., the surveyor emailed registered nurse (RN)-C indicating an off-site follow-up survey would be conducted via telephone and email and requested completed documentation supporting follow through with their plan of correction for bed rails. The email indicated the documentation needed to be provided by 11:00 a.m., on November 29th, 2022. On November 29th, 2022, at 9:27 a.m. during a phone interview, RN-C stated she was 45 minutes away from the facility. RN-C requested an extension until 12:00 p.m., on November 29th, 2022, due to her drive time and weather conditions, which the surveyor granted. The surveyor explained to RN-C the only documentation required was for the previous bed rail citation (state citation identification number 2310) from the September 26th, 2022, survey and not for the other citations which were issued during the same survey. On November 29th, 2022, at 11:40 a.m., RN-C emailed the surveyor indicating she had arrived at the facility and would be sending the requested document after she gathered them. On November 29th, 2022, at 1:11 p.m., the surveyor had not received any documentation and emailed RN-C indicating RN-C had until 2:15 p.m. to produce the requested documentation or risk the possibility of the citation being reissued. On November 29th, 2022, at 1:48 p.m. during a phone interview, RN-C stated she was having	02310		

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02310	Continued From page 10	02310		

difficulty finding the requested documentation. The surveyor again stated the documentation requested was only for the bed rail citation from the survey on September 26th, 2022. RN-C verbalized understanding but stated she was not finding all the documents needed. RN-C stated she had some items ready. The surveyor stated RN-C would need to send what she had available and reminded RN-C of the approaching 2:15 p.m. deadline.

On November 29th, 2022, at 2:15 p.m., the surveyor had not received any documentation from RN-C.

On November 29th, 2022, at 2:19 p.m., the surveyor emailed RN-C and indicated no documentation had been received and that the reissue of the citation was likely.

On November 29th, 2022, at 2:20 p.m. during a phone interview, RN-C stated she had emailed some documents to the surveyor, but the surveyor had not received them.

On November 29th, 2022, at 2:23 p.m. and 2:33 p.m., RN-C emailed some of the requested progress notes and assessments for residents to the surveyor.

During a phone interview on November 29th, 2022, at 3:20 p.m., RN-C stated when the Minnesota Department of Health was onsite on September 26, 2022, she had completed all of the assessment forms and measurements herself for all residents with bed rails the same day. RN-C stated the documentation should have been loaded into their Eldermark (electronic documentation program). RN-C stated when she arrived at the facility today, November 29, 2022,

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02310	Continued From page 11 the documentation she had completed was nowhere to be found. RN-C stated two nurses, who were no longer employed by the licensee, were supposed to have loaded the documentation into Eldermark. RN-C stated the bed rails were to be inspected by their maintenance crew every 30 days and that had been completed the week prior. RN-C stated the maintenance crew was unable to produce documentation the inspections had been completed. RN-C stated throughout the day on November 29th, 2022, she had been recreating the documentation she had completed on September 26th, 2022. No documentation had been provided prior to the November 29th, 2022, 2:15 p.m. deadline, which was more than five hours after initial contact with RN-C. As of November 30th, 2022, at 10:22 a.m., no additional documentation had been provided.	02310		

Electronically Delivered

October 21, 2022

Administrator
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN 55110

RE: Project Number(s) SL30557015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 28, 2022, 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), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30557	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL30557015 On September 26, 2022, through September 28, 2022, 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 forty (40) residents, all of whom received services under the provider's Assisted Living with Dementia Care license. On September 26, 2022, an immediate correction order was issued at 2310. On September 27, 2022, at 11:45 a.m., the immediacy of the order was removed, the scope and level of noncompliance remained the same.	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 with Dementia Care 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.	

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0 470	Continued From page 1	0 470		
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; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During tour of the facility on September 27, 2022, at 10:00 a.m., the facility lacked a complete posted staff schedule. The staff schedule that was posted included shift and names of employees, but lacked hours worked. On September 27, 2022, at 11:00 a.m., housing manager (HM)-A confirmed the licensee had not completed the staffing schedule to be posted, and HM-A was not aware of that requirement. The licensee's Staffing and Scheduling policy, dated August 1, 2021, directed the licensee post a 24-hour staffing schedule that identifies staff member, shifts, days worked, hours worked, and assignments or locations for staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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:	0 480		

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0 480	Continued From page 3 (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 practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 26, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post an emergency disaster plan prominently, and the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all forty (40) residents receiving assisted living services, staff, and visitors.	0 680		

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0 680	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During tour of the facility on September 27, 2022, at 10:00 a.m., the licensee's emergency disaster plan was not posted prominently. On September 27, 2022, at 11:00 a.m., housing manager (HM)-A confirmed that the emergency disaster plan was not posted, and HM-A was not aware of that requirement. The licensee's plan lacked the following required content: -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -development of all policies/procedures, based on assessment, and additional policies for: -handling and use of volunteers. On September 27, 2022, at 1:10 p.m., director of nursing (DON)-E confirmed the licensee did not complete a full-scale community wide exercise with state and local EP officials/organizations or have a policy in place for handling and use of	0 680		

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0 680	Continued From page 6 volunteers. The licensee's Emergency Preparedness Plan policy, dated August 16, 2022, indicated the licensee would have in place a general emergency preparedness plan, but posting of the emergency disaster plan was not included in the policy. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy, dated August 16, 2022, indicated the licensee would conduct a full-scale community wide exercise annually and the emergency preparedness plan would include a communications plan focusing on staff, entities under arrangement, other LTC providers, volunteers, family members, state and federal contacts, and other sources of assistance. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	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	0 730		

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0 730	Continued From page 7 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 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 one of four residents (R4).	0 730		

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0 730	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's service plan, dated June 28, 2022, indicated services including daily application and removal of bilateral leg braces, reassurance checks four times a day, daily assistance with dressing, grooming, and bathing, and escorts to meals and activities. R4's September 2022, Service Checkoff List included boxes for unlicensed personnel (ULP) to initial when cares and services were completed daily. R4's cares and services were not entered consistently and did not include documentation all services were provided. On September 27, 2022, at 11:10 a.m., director of nursing (DON)-F confirmed the Service Checkoff List for ULP's was not consistently completed by ULP. DON-F verified ULP are trained to document the cares and services provided for the licensee client's. The licensee's Resident Record-Information and Content policy, dated August 1, 2021, verified "staff providing assisted living services will document daily, medications, services, treatments, or therapies provided to resident [client]."	0 730		

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0 730	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarms in resident units 114, 115, 237, and 238. This has	0 780		

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0 780	Continued From page 10 the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 28, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the director of maintenance (DOM)-H. During the tour, survey staff observed and the DOM-H verified in the one-bedroom resident units, 114, 115, 237, and 238 had missing smoke alarms outside within the vicinity of the sleeping room of each unit. Survey staff also explained to the DOM-H that the missing smoke alarm outside the vicinity of the sleeping room of each unit must be interconnected with the existing smoke alarm inside the sleeping room as required in a dwelling unit. On September 28, 2022, at approximately 2:15 p.m., during the exit interview, the licensed assisted living director-B and the DOM-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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0 800	Continued From page 11	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 28, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the director of maintenance (DOM)-H. During the tour, survey staff observed and the DOM-H verified the following: 1)The one-hour fire-rated stairway door (next to resident room 226) failed to latch when closed. The door hardware needs to be repaired or replaced to enable the door to latch when closed. 2) In the resident room107, the room had a missing room door hardware and a window	0 800		

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	30557	A. BUILDING: _____ B. WING _____	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 screen. The DOM-H confirmed the findings and placed a call to the locksmith to arrange for repair at the time of the tour. 3) No carbon monoxide alarms and/or detection systems were provided at the required locations of resident sleeping rooms and in mechanical rooms for the safety of residents by providing carbon monoxide alarms in buildings with forced air fuel-burning equipment/appliance in accordance with state law. The DOM-H confirmed the findings and placed a call to a contractor. On September 28, 2022, at approximately 2:15 p.m., during the exit interview, the licensed assisted living director-B and the DOM-H acknowledged the above findings. No further information was 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	0 810		

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0 810	Continued From page 13 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the minimum required employee training on fire safety and evacuation and the required annual training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire or similar emergency. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. 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).	0 810		

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0 810	Continued From page 14 The findings include: On September 28, 2022, at approximately 1:05 pm, survey staff received the facility fire safety and evacuation plan and related documentation for review. Document review indicated the following findings: 1) Documentation review showed the licensee lacked a record of employee training specifically on the fire safety and evacuation plan. Survey staff explained that the employee training on the fire safety and evacuation plan in accordance with Minnesota Statutes is upon hire and at least twice a year thereafter, in addition to the annual required emergency preparedness plan training (EPP). Record provided for the review was the facility's annual EPP training (Human Hazards) dated September 23, 2022. 2) No record was provided for review to show resident training that can self-assist in their evacuation on the proper actions to be taken in the event of a fire or similar emergency. On September 28, 2022, at approximately 2:15 p.m., during the exit interview, the licensed assisted living director (LALD)-B and the director of maintenance-H acknowledged the above findings. The LALD-B stated that she had records for the training and needed to look for them. Survey staff stated that additional documentation will be honored if received (via email) by the end of September 29, 2022, for review. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

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0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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: On September 26, 2022, at approximately 10:00 a.m., during the entrance conference, a copy of the facility's assisted living contract was requested. The licensee's assisted living contract included: "Personal Property of Resident; No Liability of Management. Management has no responsibility	0 970		

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0 970	Continued From page 16 to Resident or any third party for any personal property placed in the Residency unit or any other location within the Facility or on its grounds by the owner of such personal property. Management is not responsible to Resident or any third party for loss of any personal property by theft or any other cause. Resident assumes all risk of harm or loss to any of Resident's personal property." On September 27, 2022, at 10:23 a.m., director of nursing (DON)-F confirmed the assisted living contract was used for all residents. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, verified the licensee "emphasize to the prospective resident and/or responsible person that the assisted living contract is a legal, binding contract." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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	01440		

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01440	Continued From page 17 and must include observation of the staff administering the medication or treatment and the 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 record review and interview, the licensee failed to ensure the registered nurse (RN), or appropriate licensed health care professional conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired to provide assisted living services on April 5, 2022. The employee record of ULP-E did not contain documentation that ULP-E had been supervised	01440		

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01440	Continued From page 18 after performing delegated tasks. On September 27, 2022, at 1:20 p.m., director of nursing (DON)-F verified there was no documentation that ULP-E had been supervised after performing delegated tasks. The licensee's Supervision of Staff-Delegated Services policy, dated August 1, 2021, directed staff who provide delegated tasks will be supervised by an RN or appropriate licensed health professional, and must be provided within 30 calendar days after the date on which the individual begins working for the licensee, and first performs the delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations for refrigerated medications in one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 19 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: On September 27, 2022, at 8:45 a.m., the medication refrigerator located on the first floor, where NovoLog flex pens, Lantus, Tresiba flex pens, gabapentin solution, acetaminophen suppositories, latanoprost solution, timolol solution and bisacodyl suppositories were stored, lacked temperature recordings for thirteen of twenty seven days, September 1, 2022 through September 27, 2022. The manufactures instructions for storage of the above listed refrigerated medications are between (36-46 degrees Fahrenheit (F)). On September 27, 2022, at 2:24 p.m., director of nursing (DON)-F stated, "nurses are responsible for the temperature logbook." The licensee's Storage of Medications policy, dated August 1, 2021, indicated that medications would be stored per manufacturer's recommendations, refrigerated, room temperature, or frozen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02310	Continued From page 20	02310		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for four of four residents (R2, R3, R4, R5) who utilized bed rails with records reviewed. This resulted in issuance of an immediate correction order on September 26, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 26, 2022, at approximately 2:15 p.m., the surveyor observed bilateral half bedrails on the upper sides of the hospital beds for R2, R3, and R4, and a unilateral half bedrail on the upper side of the hospital bed for R5. Diagnoses for R2, R3, R4 and R5 were dementia, sepsis, cerebral palsy, and subarachnoid hemorrhage, respectively. The services plans for	02310		

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02310	Continued From page 21 R2, R3, R4 and R5 dated, July 20, 2022, July 29, 2022, June 28, 2022, and January 28, 2022 respectively. The service plans for R2, R3, R4 and R5, dated, July 20, 2022, July 29, 2022, June 28, 2022, and January 28, 2022, respectively, indicated services provided included assistance with activities of daily living and medication management. On September 26, 2022, at 2:30 p.m., registered nurse (RN)-D verified bedrails had not been assessed for safety with measurements, nor was the education provided to the resident/resident representative on the risks associated with bed rail use documented. On September 26, 2022., at 3:45 p.m., licensed assisted living director (LALD)-B confirmed staff had not been trained to notify the registered nurse if bedrails were applied to a resident's bed. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of correction order, tag	02310		

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02310	Continued From page 22 identification 2310 was removed September 27, 2022, scope and level of noncompliance remained the same. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *09/26/22*
Time: 13:26:16
Report: 8058221186

Food and Beverage Establishment Inspection Report

Location:
White Bear Lake White Pine
1235 Gun Club Road
White Bear Lake, MN55110
Ramsey County, 62

Establishment Info:
ID #: 0039410
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517573800
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.

2-100 Supervision

2-102.12AMN

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

CURRENTLY KITCHEN MANAGER IS SCHEDULING A CLASS/TESTING DATE

Comply By: 01/31/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

ICE MACHINE SHOWS SIGNIFICANT AMOUNTS OF CONDENSATION COLLECTING ON EXTERIOR OF LID WHICH DRAINS BACK INTO THE ICE BIN ONCE HANDLED AND CLOSED - REPAIR OR REPLACE ICE MACHINE

Comply By: 10/05/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Hot Water: = --- at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: EGG ROLL
Temperature: 180 Degrees Fahrenheit - Location: OVEN
Violation Issued: No

Process/Item: JELO
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD REPRESENTATIVE: RHONDA MAKELA

SENIOR LIVING CENTER, WHITE BEAR LAKE, FULL COMMERCIAL FACILITY

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 8058221186 of 09/26/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____

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