Electronically Delivered

July 3, 2024

Licensee
Waters Edge
1841 Eagle View Circle
Albert Lea, MN 56007

RE: Project Number(s) SL32524015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

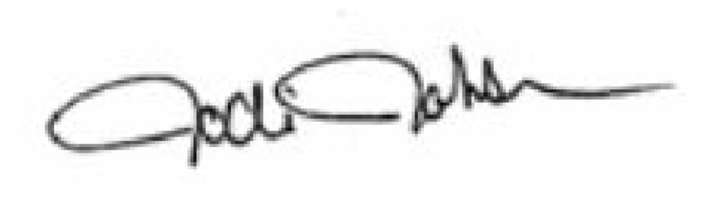
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32524	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE	1841 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32524015 On June 3, 2024, through June 6, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 48 residents; zero receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 staff posting included all the required elements, potentially affecting all the licensee's residents, staff, and visitors. 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	0 470		

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0 470	Continued From page 2 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings included: During the entrance conference on June 3, 2024, at 11:20 a.m. assistant administrator (AA)-B stated the licensee currently had a census of 48 residents; none of which were receiving assisted living services. If one of the independent living residents pushed their pendant or call light in an emergency, the clinical nurse supervisor (CNS) would respond Monday thru Friday from 9:00 a.m. to 4:00 p.m. After hours and on the weekend, staff at the attached assisted living facility with dementia care (ALFDC) would respond to the call. On June 3, 2024, at 12:29 p.m. the surveyor toured the facility with AA-B. In the common area outside of the dining room was a bulletin board with several postings. The posted staff schedule indicated the housekeeper worked Monday through Friday from 8:00 a.m. to 3:00 p.m.; this was the only staff listed on the posting. AA-B stated CNS-C's hours should also be included on the posted staff schedule. AA-B was unaware the staff schedule from the ALFDC should also be included in the posting as they would be expected to respond to an urgent pendant/call light request after normal business hours. The licensee's Direct Care Staffing Plan reviewed May 22, 2024, indicated: There will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety need. Staffing schedules and daily postings will reflect the determination of	0 470		

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0 470	Continued From page 3 what is needed for an adequate number of staff. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and	0 550		

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0 550	Continued From page 4 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 June 3, 2024, at 12:29 p.m. the surveyor toured the facility with assistant administrator (AA)-B. In the common area outside of the dining room was a bulletin board with several postings. The surveyor reviewed the postings; there was no evidence the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities was posted in a conspicuous place. AA-B stated the above content was not posted. The licensee's Complaint Policy and Procedure, undated, indicated: 1. Each resident or resident representative receives written notice of our facility's process for receiving and resolving complaints/grievances. The procedure will also be posted in a conspicuous location. 2. The written notice includes: a. The resident's right to complain to our facility about the services received from our staff; b. The method of submitting a complaint to our facility ; and c. A description of the facility's complaint	0 550		

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0 550	Continued From page 5 resolution process available to residents d. The name, telephone number and email contact information for the staff person(s) responsible for handling grievances. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the MN Adult Abuse Reporting Center (MAARC). The notice will state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the MN Department of Health. f. A statement that our facility will not take any action that negatively affects a resident in retaliation for a complaint made or a concern expressed by the resident or the resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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,	0 730		

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0 730	Continued From page 6 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 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 the required documentation of all	0 730		

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0 730	Continued From page 7 provided services, documentation related to hospitalization, and a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Documented services R1's start of care was December 4, 2024, with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and emphysema. R1's service plan dated December 4, 2024, indicated R1 received assistance with bathing twice weekly and companion care with a meal once daily. R1's documentation of services dated December 1, 2023, thru December 31, 2023, indicated staff had provided companion care with a meal on December 8, 2023, and December 11, 2023, and showering assistance on December 7, 2023, and December 11, 2023. R1's record had no documentation of services received in January 2024, or February 2024. On June 4, 2024, at 11:00 a.m. clinical nurse supervisor (CNS)-C reviewed R1's	0 730		

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0 730	Continued From page 8 documentation of services and confirmed they were not always being documented as provided; R1's spouse had eventually discontinued the meal services but continued with the twice weekly showering. CNS-C further stated R1 was routinely getting showering assistance; however, staff were not documenting it. The licensee's Resident Records policy, undated, indicated the resident record will contain documentation that services have been provided as identified in the service plan. Hospitalization R1's progress notes dated February 21, 2024, indicated R1 had arrived on the unit at the attached skilled nursing facility (SNF) via stretcher van service, was admitted to the Woodlands campus (SNF), and further was admitted to hospice services. The last progress note prior to this was dated February 9, 2024; there were no progress notes related to R1's hospitalization. On June 4, 2024, at 9:56 a.m. clinical nurse supervisor (CNS)-C reviewed R1's progress notes and stated they did not include documentation of R1's hospitalization and what led up to it, stating, "We didn't document." The surveyor requested R1's After Visit Summary. R1's hospital After Visit Summary dated February 21, 2024, indicated R1 had been hospitalized from February 14, 2024, thru February 21, 2024, due to pneumothorax (collapsed lung) secondary due to emphysema and adult failure to thrive. The licensee's Resident Records policy, undated, indicated the resident record will contain documentation of significant changes in the	0 730		

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0 730	Continued From page 9 resident's status and actions taken in response to these changes and the resident's needs, including reporting to the appropriate supervisor or health care professional. Discharge summary R1's start of care for services was December 4, 2023, and discharged from the facility on February 21, 2024. R1's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On June 4, 2024, at 10:26 a.m. CNS-C reviewed R1's discharge summary dated February 21, 2024, and stated it did not include all required content. The licensee's Contract Termination policy, undated, indicated: 14. Resident discharge summary. At the time of discharge, the facility will provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes: a) a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; b) a final summary of the resident's status	0 730		

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0 730	Continued From page 10 from the latest assessment or review if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; c) a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the-counter medications; and d) a post-discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=E	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	0 780		

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0 780	Continued From page 11 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 smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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 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). Findings include: On a facility tour on June 6, 2024, at 9:00 a.m., with director of environmental services (DES-F) and maintenance coordinator (MC-G), the following was observed: It was observed in resident units 213 that the	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 12 smoke alarms located inside the bedrooms were not interconnected to each other. The bedroom smoke alarms were only interconnected with the smoke alarm outside and in the immediate vicinity of the bedrooms. It was observed in resident unit 216 that the smoke alarms located inside the bedrooms were not interconnected to each other. The bedroom smoke alarms were only interconnected with the smoke alarm outside and in the immediate vicinity of the bedrooms. It was observed in resident unit 218 that the smoke alarms located inside the bedrooms were not interconnected to each other. The bedroom smoke alarms were only interconnected with the smoke alarm outside and in the immediate vicinity of the bedrooms. It was observed in resident unit 112 that the smoke alarm located inside the bedroom adjacent to the kitchen was not interconnected to the smoke alarm inside the other bedroom or with the smoke alarm outside and in the immediate vicinity of the bedrooms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour DES-F and MC-G were asked to test the smoke alarms. DES-F and MC-G, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32524	A. BUILDING: _____ B. WING _____	06/06/2024

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WATERS EDGE	1841 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(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 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 6, 2024, at 9:00 a.m., with director of environmental services (DES-F) and maintenance coordinator (MC-G), the following was observed: It was observed that the two sets of 90-minute fire rated doors leading from the Waters Edge portion	0 800		

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	32524	A. BUILDING: _____ B. WING _____	06/06/2024

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0 800	Continued From page 14 of the facility into the Town Center portion of the facility did not fully close and latch when released from the magnetic hold open devices. This was observed at both sets of doors in this location. Fire doors must be maintained so they close and latch properly to prevent the spread of fire to separate areas of the building. DES-F stated that they would have maintenance adjust the doors. It was observed that the labeled fire doors leading into resident units 102, 112, 113, 116, and 120 did not self-close and latch. Labeled fire doors that are provided with self-closing hinges must be maintained to close and latch to prevent the spread of fire. DES-F stated he wasn't aware that the doors had that type of hinge. It was observed that the trash chute door labeled "rubbish" in the second-floor trash room was missing the latch. Trash chute doors are required to self-close and latch to prevent the spread of fire to adjacent floors. DES-F stated they thought they had a new latch that could be installed. Water stains were observed on a ceiling tile in room W243 and the first-floor exit hallway adjacent to resident unit 118. It was observed in stair W1 that the paint was loose and peeling where the ceiling and wall meet. It was observed in resident unit 109 there was a water stain on the ceiling in the bathroom. DES-F and MC-G verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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	32524	A. BUILDING: _____ B. WING _____	06/06/2024

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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 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 observation, interview, and record	0 810		

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0 810	Continued From page 16 review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 6, 2024, at 10:40 a.m., the director of environmental services (DES-F), maintenance coordinator (MC-G), and registered nurse/clinical manager (CNS-C) provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP, titled "St. John's Lutheran Community on Fountain Lake Fire Emergency Plan", undated, failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. The FSEP included an evacuation floor plan, but the plan did not include the location and number	0 810		

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0 810	Continued From page 17 of resident rooms. During interview on June 6, 2024, at 11:35 a.m., DES-F verified the evacuation floor plan did not include the number and location of resident rooms, and stated they would update the plan and make it more legible. During same interview, CNS-C stated they would update the FSEP to include resident needs and evacuation procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 18 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01060		

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01060	Continued From page 19 R1's start of care was December 4, 2024, with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and emphysema. R1's service plan dated December 4, 2024, indicated R1 received assistance with bathing twice weekly and companion care with a meal once daily. R1's hospital After Visit Summary dated February 21, 2024, indicated R1 had been hospitalized from February 14, 2024, thru February 21, 2024, due to pneumothorax (collapsed lung) secondary due to emphysema and adult failure to thrive. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 4, 2024, at 10:26 a.m. clinical nurse supervisor (CNS)-C stated she did not provide a written notice to R1 related to the emergency relocation, although did discuss with R1's spouse. CNS-C further stated not providing written notice	01060		

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01060	Continued From page 20 to the ombudsman, although knew the attached assisted living with dementia care facility was doing this, but didn't think about having to do it here. The licensee's Contract Termination policy, undated, indicated: 8. Emergency relocation B. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. (6) The notice required will be delivered as soon as practicable to" a) the resident, legal representative, and designated representative; b) for resident who receive home and community-based waiver services under the resident's case manager; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 21 No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/05/24*
Time: 10:46:59
Report: 8044241128

Food and Beverage Establishment Inspection Report

Location:
Waters Edge - Water's Edge
1841 Eagle View Circle
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:
ID #: 0038550
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073738226
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.15B ***** Priority 2 *****

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

Waffle batter cooling covered container.
Comply By: 06/05/24

Surface and Equipment Sanitizers

Hot Water: = at 163.7 Degrees Fahrenheit
Location: Upstairs dishwasher
Violation Issued: No

Hot Water: = at 170.0 Degrees Fahrenheit
Location: Downstairs dishwasher
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38.7 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Type: Full
Date: *06/05/24*
Time: 10:46:59
Report: 8044241128
Waters Edge - Water's Edge

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 36.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Process/Item: Cooling
Temperature: 55.1 Degrees Fahrenheit - Location: Waffle batter @ 11:00am
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.5 Degrees Fahrenheit - Location: Cut melon in downstairs upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35.0 Degrees Fahrenheit - Location: Downstairs upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: Downstairs upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.9 Degrees Fahrenheit - Location: Rice in WIC
Violation Issued: No

Process/Item: Cooking
Temperature: 175.6 Degrees Fahrenheit - Location: Ground beef
Violation Issued: No

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

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 8044241128 of 06/05/24.

Certified Food Protection Manager: Carrie A. Seath

Certification Number: FM91652 Expires: 11/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Brandy

Signed: _____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us