Electronically Delivered

March 1, 2022

Administrator
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights, MN 55120

RE: Project Number(s) SL29408015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 20, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. 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 surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WHITE PINE	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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 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: SL29408015 On January 18, 2022, through January 20, 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 38 residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care license providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 according to the Minnesota Food Code. This had the potential to affect all 38 current residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the additional documentation	0 480		

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0 480	Continued From page 2 included in the Food and Beverage Establishment Inspection Reports, dated January 18, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment (PPE), ensure personal protective equipment was available to staff, and ensure adequate procedures for isolation of COVID-19 positive residents. This had the potential to affect all 38 residents, staff, and visitors in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 3	0 510		

safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:
The licensee failed to ensure staff wore appropriate PPE per the Center for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines.

R1's diagnosis included dementia. R1's Individualized Service Plan Agreement, dated January 19, 2022, indicated R1's services included reassurance checks, toileting, bathing assistance, behavioral interventions, and dressing and grooming.

On January 19, 2022, at approximately 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-H providing morning cares for R1. ULP-H donned a surgical face mask, gloves and a faceshield; however, ULP-H did not don a gown. The surveyor observed no signage on R1's door or near the entrance to R1's room for Covid-19 precautions. ULP-H did not remove PPE prior to exiting R1's room.

On January 20, 2022, at approximately 9:20 a.m., the surveyor observed ULP-J and ULP-K providing morning cares for R1. ULP-J and ULP-K donned a surgical face mask, gloves and a faceshieldl however, ULP-J and ULP-K did not don a gown. The surveyor observed no Covid-19 precautions signage on R1's door or near the entrance to R1's room. At approximately 9:30 a.m., ULP-H entered R1's room. ULP-H donned a surgical face mask, gloves and a faceshield;

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0 510	Continued From page 4 however, ULP-H did not don a gown. On January 20, 2022, at approximately 10:00 a.m., family member (F)-1 stated R1 tested positive for Covid-19, and the family was notified by the facility on January 18, 2022, via voicemail. F1 was informed on January 19, 2022, (unknown time) by registered nurse (RN)-D that R1 would be quarantined in her room for ten days. On January 20, 2022, at approximately 10:15 a.m., registered nurse (RN)-E verified R1 tested positive for Covid-19 on January 18, 2022. RN-E further stated R1 did not have a PPE cart outside of her room or PPE supplies inside of R1's room. RN-E verified licensee's employees did not wear the appropriate PPE when entering and exiting R1's room. On January 20, 2022, at approximately 10:30 a.m., the surveyor observed no Covid-19 signage to include A Droplet Precaution sign, Contact Precaution sign or Red Hand sign was observed outside of R1's room. Upon further observation, neither a PPE cart or Biohazard bin were found near R1's door or inside the room On January 20, 2022, at approximately 11:30 a.m., the surveyor observed a PPE cart was placed outside of R1's room. On January 20, 2022, at approximately 3:15 p.m., director of nursing (DON)-B clarified a PPE cart should have been placed outside of R1's door, R1 should have been quarantined inside her room for ten days per house protocol, and licensee's employees should have been immediately notified regarding R1's positive Covid-19 status.	0 510		

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0 510	Continued From page 5 The White Pine/Comfort of Home and Gracewood sheet entitled, What do you do if a resident is showing signs of Covid -19 or tested positive for Covid-10 (sp), directed caregivers to do the following: -isolate the resident in their room -immediately contact the nurse -take PPE bin or cart and place outside the resident's room -place Droplet Precaution sign on the resident's door (located inside PPE bin) -place Contact Precaution sign on the resident's door (located inside PPE bin) -place Red Hand (sign) on the resident's door (located inside PPE bin) -place trash can directly outside the resident's room with red biohazard bag to dispose of PPE before leaving the room -prior to entering the resident's room, a mask, gown, eye protection and gloves should be worn within six feet of the resident -when leaving the resident's room, dispose of gowns, gloves and mask in designated trash can in the resident's room BEFORE leaving the room. Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated June 30, 2021, indicated health care workers (HCW's) with face-to-face contact with a suspected or confirmed Covid positive residents should wear a gown, gloves, amedical grade well-fitting facemask and eye protection. No further information provided. TIME PERIOD TO CORRECT: Two (2) days.	0 510		

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0 630	Continued From page 6	0 630		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee's individual abuse prevention plan (IAPP) failed to include an assessment of a resident's susceptibility to abuse by another resident; a resident's risk to abuse another resident; and interventions of the specific measures to be taken by staff to minimize the risk of abuse for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 630		

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0 630	Continued From page 7 R2 was admitted with diagnoses included recurrent falls and major depressive disorder. R2's Individualized Service Plan Agreement dated October 4, 2021, indicated R2's services included medication administration, transfer assistance, escorts to and from activities, meals and toileting. On January 20, 2022, at 9:05 a.m., the surveyor observed R2 in a chair in her room. R2 stated she was admitted to the facility a few months ago due to falls at home. R2 stated she needed to call for assistance and was told by staff not to walk by herself in the room, but often needed to wait long periods of time for assistance or forgets to call for assistance. R2's Vulnerability Assessment and Prevention Plan dated January 13, 2022, identified R2 "becomes disoriented and/or lost in unfamiliar settings, does not demonstrate safe pedestrian skills, does not demonstrate recognition of traffic hazards, does not demonstrate ability to use public transportation." R2's assessment included "can sometimes be verbally aggressive" with interventions of redirection and communication, and "intermittent confusion and short term memory loss" with no documented interventions. R2's assessment lacked statements of the specific measures to be taken by staff to minimize the risk of falls and verbal aggression. On January 20, 2022, at 2:15 p.m., the director of nursing (DON)-B verified R2's IAPP was not complete and lacked individualized interventions for falls and verbal aggression. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 1, 2021, verified the licensee "develops individualized vulnerable adult abuse prevention	0 630		

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0 630	Continued From page 8 plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information." No further information was provided.	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of two unlicensed personnel (ULP-H) with employee records reviewed.	0 660		

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0 660	Continued From page 9 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-H's employee records lacked evidence of baseline TB history and symptoms screening or evidence of screening for active TB with either a two-step TST or blood test. ULP-H was hired on November 18, 2021, to provide direct care services. On January 19, 2022, at approximately 7:50 a.m., the surveyor observed ULP-H assisting R1 with toileting, dressing, grooming and oral care. On January 19, 2022, at approximately 3:20 p.m., director of nursing (DON)-B verified ULP-H's employee record lacked evidence a history and symptoms screening, as well as screening for active TB was completed and documented. DON-B stated although she believed ULP-H completed the history and symptoms screening and screening for active TB, she expected the results to be current and documented in ULP-H's employee record. The licensee's Tuberculosis Screening policy dated August 1, 2022, indicated licensee's employees would be screened for TB with a history and symptom screening and active TB upon hire. The policy identified the results of the	0 660		

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0 660	Continued From page 10 TB screening would be included in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 660		
0 730 SS=F	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;	0 730		

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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
0 730	Continued From page 11 (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 staff documented resident cares provided in the resident record for two of three residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's January 2022, Medication Administration Record identified R1's diagnosis as dementia.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	01/20/2022

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0 730	Continued From page 12 R1's Individualized Service Plan Agreement dated January 19, 2022, indicated services included reassurance checks, toileting, bathing, behavioral interventions, dressing and grooming, escorts, feeding, medication administration, oral care, oxygen, and transfer assistance. R1's Service Checkoff List dated January 2022 indicated staff would complete R1's reassurance checks at 12:30 a.m., 2:30 a.m., 4:30 a.m., 6:30 a.m., 8:30 a.m., 10:30 a.m., 12:30 p.m., 2:30 p.m., 4:30 p.m., 6:30 p.m. 8:30 p.m., and 10:30 p.m. R1's Service Checkoff List lacked documentation staff completed reassurance checks completed during the above times on January 3, 6, 7, 8, 10, 12, 14, 16, 17, 18 and 19, 2022. R1's Service Checkoff List dated January 2022 indicated staff would complete toileting assistance at 1:30 a.m., 3:30 a.m., 5:30 a.m., 7:30 a.m., 9:30 a.m., 11:30 a.m., 1:30 p.m. 3:30 p.m., 5:30 p.m., 7:30 p.m., 9:30 p.m., and 11:30 p.m. R1's Service Checkoff List lacked documentation staff completed toileting assistance at the above times on January 1, 2, 3, 6, 7, 8, 10, 12, 14, 15, 16, 17, and 18, 2022. R1's Service Checkoff List dated January 2022 indicated staff would complete behavioral intervention, dressing and grooming, escorts, feeding assistance, medication administration, oxygen, and transfer assistance daily. R1's Service Checkoff List lacked documentation the above daily services on January 1, 2, 3, 7, 8, 9, 13, 14, 15, 16, 17, and 18, 2022. The same document indicated staff would assist R1 with bathing bi-weekly. R1's Service Checkoff List lacked documentation staff completed bathing assistance on January 7, 14, and 18, 2022.	0 730		

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0 730	Continued From page 13 R1's evening shift Service Checkoff List indicated staff would complete behavioral interventions, dressing and grooming, escorts, feeding assistance, medication administration, oral care, oxygen, and transfer assistance daily. R1's Service Checkoff List lacked documentation staff completed the above daily services on January 1, 2, 8, 9, 10, 14, 15, and 16, 2022. The noc (night) shift service checkoff included assistance from staff with oxygen and transfer assistance. The service checkoff lacked documentation on January 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, and 18, January 2022. R2 was admitted with diagnoses of recurrent falls and major depressive disorder. R2's Individualized Service Plan Agreement dated October 4, 2021, indicated R2's services included medication administration, transfer assistance, reassurance checks, and toileting. R2's Service Checkoff List for January 2022, indicated staff would complete R2's reassurance checks at 12:30 a.m., 2:30 a.m., 4:30 a.m., and 6:30 a.m. The service check off lacked documentation of reassurance checks completed during the above times on January 4, 6, 7, 8, 10, 11, 12, 13, 14, and 15, 2022. R2's Service Checkoff List for January 2022 indicated staff would complete R2's toileting assistance at 1:30 a.m., 3:30 a.m., and 5:30 a.m. R2's Service Check off List lacked documentation staff toileted R2 at the above times on January 6, 7, 8, 10, 11, 12, 13, 14, and 15, 2022. R2's day shift Service Checkoff List for January	0 730		

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0 730	Continued From page 14 2022 indicated staff completed R2's dressing and grooming daily, reassurance checks at 8:30 a.m., 10:30 a.m., 12:30 p.m., and 2:30 p.m., and toileting assistance at 7:30 a.m., 9:30 a.m., 11:30 a.m., and 1:30 p.m.. R2's Service Checkoff List lacked documentation staff completed R2's toileting and reassurance checks from January 1, 2022 through January 16, 2022. R2's evening shift Service Checkoff List dated January 2022 indicated staff would complete R2's dressing and grooming daily, reassurance checks at 4:30 p.m., 6:30 p.m., 8:30 p.m., and 10:30 p.m., and toileting at 3:30 p.m., 5:30 p.m., 7:30 p.m., 9:30 p.m., and 11:30 p.m. R2's Service Checkoff List lacked documentation staff completed toileting and reassurance checks on January 1, 2, 6, 7, 9, 10, 11, 12, 13, 14, 15, and 16, 2022. On January 20, 2022, at 2:55 p.m., director of nursing (DON)-B verified R1 and R2's Service Checkoff Lists were not consistently completed by the unlicensed personnel (ULP), on each shift. DON-B stated she was aware of the lack of documentation, and had worked with the ULP's to ensure staff documented services completed on each shift. The licensee's Resident Record-Documentation policy dated August 1, 2021, indicated "Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 790	Continued From page 15	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 20, 2022, between 9:45 a.m. and 1:00 p.m., survey staff toured the facility with the	0 790		

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0 790	Continued From page 16 maintenance assistant(MA)-I. Survey staff observed portable fire extinguishers were tagged showing the required consistent annual service date of 10/2021, but no monthly visual inspections were performed and recorded for all portable fire extinguishers located in the corridor throughout the facility, in the kitchen, and the mechanical rooms. On January 20, 2022, at approximately 10:20 a.m., the MA-I confirmed the finding during the tour as he stated he was not aware of the visual monthly inspections required on portable fire extinguishers. Survey staff explained that the monthly visual inspection of each unit was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the unit to prevent their operation. If questionable on any unit, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. On January 20, 2022, at approximately 2:20 p.m., the licensed assisted living director-A acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	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	0 800		

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0 800	Continued From page 17 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 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 20, 2022, between 9:45 a.m. and 1:00 p.m., survey staff toured the facility with the maintenance assistant-I, and the following findings were observed: -The windows in resident rooms #2, #10, #22, #30, and #45 were missing window stoppers to restrict resident elopement. -The light fixtures on the corridor wall next to room #18 were loose and not secured as they came off the wall when touched. -The wood handrail across from room #23 was loose and missing screws. -The transition strip from corridor carpet to hard floor in the great dining room was cracked and	0 800		

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0 800	Continued From page 18 not smooth, creating a potential tripping hazard for residents that shuffle as they walk. -The janitor closet across from room #26 did not latch when closed. This posed a chemical safety concern for resident access. -The window curtain railing in room #31 was falling off the bracket and had multiple missing screws on one side. -The window blind in room #28 was damaged and comprised with missing parts. Furnishings must be in good repair and operation for resident privacy. -The resident door in room #30 had a missing door closer. -The resident door in room #45 had loose door gasket strips preventing the door from properly closed to maintain a smoke-tight door. On January 20, 2022, at approximately 2:30 p.m., the licensed assisted living director-A acknowledged the above findings during the exit interview. 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	0 810		

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0 810	Continued From page 19 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, record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff and residents on fire safety and evacuation. This has the potential to directly affect the safety of 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	0 810		

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0 810	Continued From page 20 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 January 20, 2022, at approximately 1:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review: -The building layout plan lacked the number of sleeping rooms and no exits were identified, and not readily available. -The fire safety and evacuation plan documentation lacked the specific fire protection procedures necessary for addressing all residents including any unique resident-specific situations including memory care residents during an evacuation as well as a relocation of resident plan during a full evacuation. -The policy documentation lacked the content of training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter. -The documentation lacked fire protection procedures for residents. -Records showed insufficient numbers of employee fire safety evacuation drills performed to date with four drills all performed in the month of December (12/9/2021, 12/16/2021, 12/17/2021/ and 12/18/2021), and no other drills for any other months. Drills must be performed employees twice per year per shift, with at least one evacuation drill every other month. The policy documentation also lacked the content of minimum numbers of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month. On January 20, 2022, at approximately 2:40 p.m.	0 810		

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0 810	Continued From page 21 the licensed assisted living director-A acknowledged the above finds during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 22 Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked monitoring and reassessment within 14 days from the initial assessment. R2's Individualized Service Plan Agreement, dated October 4, 2021, identified R2 diagnoses of recurrent falls and Major depressive disorder, and included services of medication administration, transfer assistance, and toileting. R2's initial assessment was completed on October 4, 2021. R2's record lacked documentation an RN completed a 14-day assessment. On January 20, 2022, at 2:55 p.m., director of nursing (DON)-B stated they were unable to locate the 14-day assessment documentation for R2. DON-B stated the licensee had staffing changes. DON-B was unsure if the 14-day assessment was completed for R2. The licensee's Nursing Assessment Schedules	01620		

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01620	Continued From page 23 policy dated August 1, 2021, verified a resident assessment is completed "no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940		

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01940	Continued From page 24 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment and therapy record with all required content for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Individualized Service Plan Agreement dated October 4, 2021, identified R2's diagnoses of recurrent falls and major depressive disorder with services to include medication administration, transfer assistance, escorts to and from activities, meals and toileting. R2's hospital records dated January 14, 2022, indicated R2 was diagnosed with dysphagia, and was discharged to the licensee on a dysphagia diet with nectar thickened liquids. R2's physician orders dated January 18, 2022, included orders for Glucerna, one can two times a day, thickened to nectar thick. R2's physician orders were not included for a dysphagia diet with	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WHITE PINE	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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
01940	Continued From page 25 nectar thickened liquids. R2's record lacked an individual treatment and therapy record with the required content to include: -a statement of the type of services that would be provided -documentation of specific resident instructions related to the treatments or therapy administration -identification of treatment or therapy tasks that would be delegated to unlicensed personnel -procedures to notify a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions On January 20, 2022, at 9:30 a.m., the surveyor observed R2 with a bottld of Diet Coke and a glass of coffee on the tray table in her apartment. R2 confirmed the Diet Coke and coffee were not nectar thickened. On January 20, 2022, at 2:55 p.m. director of nursing (DON)-B stated R2 was discharged from the hospital with orders for a dysphagia diet with nectar thickened liquids. DON-B indicated R2 refused to follow the diet and nectar thickened liquid recommendations. DON-B stated the licensee had not initiated a treatment and therapy plan, as R2 refused to follow the recommendations. DON-B stated the physician was aware of R2's refusal to follow the diet and thickened liquid orders.	01940		

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	29408	A. BUILDING: _____ B. WING _____	01/20/2022

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01940	Continued From page 26 The licensee's Medications & Treatments-Administration & Delegation policy dated August 1, 2021, indicated the registered nurse/RN "will prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that will be provided to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01950		

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01950	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) specified, in writing, specific instructions for staff to follow for each resident and documented those instructions in the resident's record for one of two residents (R2) receiving a dysphagia diet and thickened liquids with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's Individualized Service Plan Agreement dated October 4, 2021, identified R2's diagnoses of recurrent falls and major depressive disorder, and included services of medication administration, transfer assistance, escorts to and from activities, meals and toileting. R2's hospital records dated January 14, 2022, indicated R2 was diagnosed with dysphagia, and was discharged to the licensee on a dysphagia diet with nectar thickened liquids. R2's physician orders dated January 18, 2022, included orders for Glucerna, one can two times a day, thickened to nectar thick. R2's physician orders were not included for a dysphagia diet with nectar thickened liquids.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 28 On January 20, 2022, at 9:30 a.m., the surveyor observed R2 had a bottle of Diet Coke and a glass of coffee on the tray table in her apartment. R2 confirmed the Diet Coke and coffee were not nectar thickened. On January 20, 2022, at 2:55 p.m. director of nursing (DON)-B stated R2 was discharged from the hospital with orders for a dysphagia diet with nectar thickened liquids. DON-B acknowledged R2's record lacked the treatment directions for a dysphagia diet and nectar thickened liquids. The licensee's Medications & Treatments-Administration & Delegation policy dated August 1, 2021, indicated the registered nurse/RN "must specify, in writing, specific instructions for each resident and document those instructions in the residents' record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system	02040		

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02040	Continued From page 29 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On January 20, 2022, between 9:45 a.m. and 1:00 p.m., survey staff toured the facility with the maintenance assistant-I. On January 20, 2022, at approximately 1:00 pm, survey staff received the HVA documentation for review: -The HVA plan lacked specific hazard assessment content on and around the property to protect the dementia care residents from harm. Hazard assessments on the HVA plan must include specific safety risks or potential hazard	02040		

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02040	Continued From page 30 vulnerabilities such as resident elopement throughout and around the memory care building including deactivation of power doors due to loss of power or fire alarm activation, the potential use of the blue emergency alarm release boxes at doors by residents, the risks of resident room windows being comprised, the potential of resident access by the use of the unrestricted windows at night in the dining room to the courtyard for an extensive period in the winter months, accessing nearby highways when elopement occurs, and the risks of the misuse of portable fire extinguishers without access restrictions or architectural accessories throughout the building. - The HVA plan lacked mitigations documentation including safety measures and/or training provided to the safety risk assessment identified on and around the property to protect all memory care residents from harm. On January 20, 2022, at approximately 2:40 p.m., survey staff explained that the licensee must develop and implement the HVA plan to protect memory care residents from harm to the licensed assisted living director (LALD)-I during the interview. All potential safety risks or harm on and around the property must be identified, assessed, and mitigated in the HVA plan documentation and implemented to protect memory care residents from harm. The LALD-I acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02410	Continued From page 31	02410		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three residents (R1) was treated with respect and dignity. 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	02410		

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02410	Continued From page 32	02410		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:
R1's Medication List printed January 20, 2022, identified R1's primary diagnosis as (advanced) dementia.

R-1's Service Checkoff List for January 2022, directed staff to provide R1 assistance with meal set-up, cutting up food, cueing and feeding.

R1's Individualized Service Plan Agreement printed January 19, 2022, verified R1's service package included feeding assistance.

On January 19, 2022, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-H providing morning cares to R1 which included toileting, oral care and dressing. At 8:30 a.m. ULP-H propelled R1 to the main dining room. ULP-H then left the dining room and returned with a washcloth and a hairbrush. At 8:40 a.m. ULP-H washed R-1's face and brushed R1's hair in the dining room with three staff members and four residents in the room. At 9:05 a.m. the surveyor observed R1 in the main dining room eating a bowl of oatmeal and a cup of thickened orange juice which had spilled on the table. R1 licked the orange juice from the table with four staff and six residents of the facility present in the room. At 9:10 a.m., a staff member walked over to R1 to provide assistance.

On January 20, 2022 at approximately 1:30 p.m. R1's family member (FM)-A stated she did not feel R1 licking juice from a table was appropriate.

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02410	Continued From page 33 On January 21, 2022 at approximately 3:15 p.m. director of nursing (DON)-B stated staff should provide personal care tasks, including grooming and hygiene in a private area. DON-B stated she would expect staff to provide feeding assistance to residents as directed by their care sheets and service plan. DON-B explained it was not acceptable for staff to allow a resident to lick orange juice from a table for any amount of time. A policy regarding maintaining resident dignity was requested but not received. DON-B provided a Care Providers of Minnesota White Pine/Gracewood Bathing Assistance policy dated June 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *01/18/22*
Time: 11:52:08
Report: 1004221014

Food and Beverage Establishment Inspection Report

Location:
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights, MN55120
Dakota County, 19

Establishment Info:
ID #: 0038977
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517887010
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

EMPLOYEE ILLNESS LOG COULD NOT BE PRODUCED DURING INSPECTION AND PERSON IN CHARGE WAS UNABLE TO VERIFY IF AN EMPLOYEE ILLNESS LOG WAS USED. ILLNESS LOG WAS PROVIDED TO THE PERSON IN CHARGE.

Comply By: 01/18/22

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR FOR THE DISH MACHINE. PROVIDE A WATER PROOF RECORDING THERMOMETER, THERMO-LABLES, OR T-STICKS, ETC TO VERIFY A UTENSILS SURFACE TEMPERATURE OF AT LEAST 160*F IS REACHED FOR SANITIZING.

Comply By: 01/18/22

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE WAS FOUND WITH REMAINING FOOD DEBRIS AND METAL SHAVINGS. CLEAN BLADE THOROUGHLY AFTER USE.

Comply By: 01/18/22

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM. ENSURE AT LEAST 1 FULL-TIME EMPLOYEE HAS TAKEN AN APPROVED FOOD SAFETY COURSE AND AFTER COMPLETION APPLIES WITH THE STATE FOR STATE CERTIFICATION. INFORMATION AND APPLICATION PROVIDED TO PERSON IN CHARGE.

Comply By: 01/18/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

HANDWASHING SINK IS NO LONGER SEALED TO THE WALL. RESEAL TO PREVENT BACKSPLASH AND DEBRIS FROM ACCUMULATING BETWEEN EQUIPMENT AND WALL SPACE.

Comply By: 01/18/22

Surface and Equipment Sanitizers

Wash Temp. Gauge: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3-COMPARTMENT SINK DISPENSER
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 35 Degrees Fahrenheit - Location: MAXIMUM REFRIGERATOR
Violation Issued: No

Process/Item: CHILI
Temperature: 32 Degrees Fahrenheit - Location: MAXIMUM REFRIGERATOR
Violation Issued: No

Process/Item: TURKEY
Temperature: 39 Degrees Fahrenheit - Location: BACK COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: LIQUID EGG
Temperature: 40 Degrees Fahrenheit - Location: BACK COOLER
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <41 Degrees Fahrenheit - Location: KITCHENETTE COOLER
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY JOLENE BERTELSEN.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-COOLING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-TEMPERATURE LOGS
-PHYSICAL FACILITIES AND MAINTENANCE
-ALL VIOLATIONS ON THIS REPORT

*ESTABLISHMENT HAS A KITCHENETTE AREA IN THE DINING ROOM THAT IS EQUIPPED WITH RESIDENTIAL EQUIPMENT (MICROWAVE, OVEN/STOVE, REFRIGERATOR), LAMINATE COUNTERS, WOODEN CABINETRY, WOODEN FLOORS, AND TEXTURED WALLS AND CEILING. AREA IS USED ONLY FOR SAME-DAY SERVICE OF ITEMS SUCH AS COOKIES DURING ACTIVITIES AND STORAGE OF MILK, JUICE, AND EMPLOYEE ITEMS. CEILING, WALLS, CABINETRY, AND COUNTERTOPS ARE FOUND TO BE IN GOOD CONDITION, FLOOR IS SHOWING SIGNS OF WEAR AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

*REPORT WAS DISCUSSED WITH THE FOOD SERVICE MANAGER, NICOLE, AND WITH THE NURSE EVALUATOR, JOLENE (HRD).

Food and Beverage Establishment Inspection Report

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 1004221014 of 01/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

NICOLE CARLSON
FOOD SERVICE MANAGER

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us