Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 10, 2023

Licensee
The Waters Of Eden Prairie
431 Prairie Center Drive
Eden Prairie, MN 55344

RE: Project Number(s) SL30812015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 16, 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.

LICENSING ORDERS
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 . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

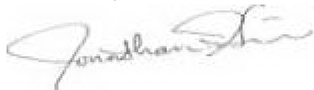
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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
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State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30812	A. BUILDING: ______ B. WING ______	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDEN PRAIRIE	**431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30812015 On November 14, 2022, through November 16, 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 one hundred fifty five (155) residents, all of whom received services under the provider's Assisted Living 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 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report dated November 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control, related to gloving and handwashing during perineal care, for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 510		

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0 510	Continued From page 3	0 510		

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:

R6's service plan dated March 16, 2022, indicated R6 received medication administration, assistance with dressing and grooming, and trainsfer assistance.

On November 15, 2022, at 8:25 a.m., unlicensed personnel (ULP)-F was observed to don gloves and assisted R6 with transferring and toileting. With gloved hands, ULP-F removed R6's soiled brief, and provided perineal care to R6. Without removing the soiled gloves and performing hand hygiene, ULP-F was observed to continue assisting R6 with dressing, and transfer to the wheelchair using a Hoyer (mechanical) lift. ULP-F then removed the soiled gloves and washed their hands. Whne quiried, ULP-F stated she was trained in infection control procedures.

On November 15, 2022, at 8:50 a.m., registered nurse/(RN)/interim memory care director of health and wellbeing (IMCD)-B stated ULP-F was trained in infection control procedures and should have removed the soiled gloves and sanitized or washed their hands in between cares.

The licensee's Standard Precautions and Infection Control policy dated February 4, 2020, indicated, "clean hands after touching blood, body fluids, secretion, excretions, and contaminated items, whether or not gloves have been worn. Clean hands immediately after gloves are removed."

No further information provided.

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content.	0 680		

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0 680	Continued From page 5	0 680		

This had the potential to affect all one hundred fifty-five (155) residents receiving assisted living services, 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).

The findings include:

On November 14, 2022, during a review of licensee's emergency preparedness plan at 1:36 p.m., the licensee lacked a written emergency disaster plan with all required content.

The licensee's plan lacked the following required content:
-process for emergency preparedness (EP) cooperation with state and local EP officials/organizations.

During an interview with senior regional director (SRD)-D on November 15, 2022, at 3:30 p.m., SRD-D stated, "We have not completed a community-based exercise, but we have one scheduled for November 17, 2002."

The licensee's Disaster Planning and Emergency Preparedness Plan policy dated November 2022, indicated the licensee would have in place an effective plan for both natural and man-made disasters and remain in compliance with state, federal, tribal, regional, and local emergency preparedness systems including State Operations

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0 680	Continued From page 6 Manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a working smoke alarm in the	0 780		

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0 780	Continued From page 7	0 780		

resident apartment unit 112 and a missing smoke alarm in the resident's sleeping room of apartment 123. This has the potential to directly affect residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 15, 2022, approximately from 11:30 a.m. to 4:00 p.m. survey staff toured the facility with the environmental manager (M)-H. During the tour, survey staff observed and the M-H confirmed the following when the smoke alarms were tested:

1) Inside the resident apartment unit 112, the required smoke alarm located outside within the immediate vicinity of the sleeping room failed to sound for proper notification.

2) Inside apartment unit 123, the smoke alarm located inside one of the two sleeping rooms failed to sound when tested by the M-H. Further investigation, the alarm was a dedicated carbon monoxide alarm rather than a smoke alarm.

On November 15, 2022, at approximately 4:30 p.m., during the exit interview, the M-H acknowledged the above findings and stated that those smoke alarms were being taken care of.

No further information was provided.

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0 780	Continued From page 8 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
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 monthly visual inspections on 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, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 790		

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0 790	Continued From page 9 The findings include: On November 15, 2022, approximately from 11:30 a.m. to 4:00 p.m. survey staff toured the facility with the environmental manager (M)-H. During the tour, survey staff observed and the M-H confirmed the portable fire extinguishers installed throughout the facility were serviced with an annual service date of October 2021 but lacked records to show the monthly visual inspections. Survey staff explained to the M-H that the portable fire extinguishers must also be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees 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 extinguisher to prevent their operation when needed. On November 15, 2022, at approximately 4:30 p.m., during the exit interview, the M-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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.	0 800		

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0 800	Continued From page 10 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) 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). On November 15, 2022, approximately from 11:30 a.m. to 4:00 p.m. survey staff toured the facility with the environmental manager (M)-H. During the tour, survey staff observed and the M-H confirmed the following: 1) Resident living units 169-188 consisted of individual fuel-burning furnaces that did not have carbon monoxide alarms and/or detection systems which were inconsistent with other resident living units. Review with the local fire marshal for the requirements. 2) Large jugs of chemicals were accessible to the residents under a cabinet in the memory care common area used for the dishwasher which posed safety concerns. The M-H stated that the dishwasher was no longer in use and will be dismantled and chemicals will be removed. Survey staff explained that all chemicals must be stored in secured locations.	0 800		

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0 800	Continued From page 11 3) Electrical panels that control the smoke alarms and the furnaces inside each memory care resident unit were readily accessible to the residents which posed safety concerns from misuse. The M-H verified the findings and stated that the panel in each resident has control of the smoke alarm and the furnace. On November 15, 2022, at approximately 4:30 p.m., during the exit interview, the M-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or 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.	0 810		

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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
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(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 the correct frequency of employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 15, 2022, at approximately 4:00 pm, survey staff received the facility fire safety and evacuation plan and related documentation for review from the environmental manager

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(M)-H. At approximately 4:30 p.m., document review and interview with the M-H indicated the following findings:

1) The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. The minimum required employee training is upon hire and twice a year for fire safety and evacuation. No record was available or provided for review.

2)The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review.

3)The records showed an insufficient number of employee evacuation drills performed to date. Drill records received for review were dated 9/17/2022 (first shift), 8/18/2022 (second shift), 4/22/2022 (second shift), and 4/20/2022 (first shift). Survey staff explained to the M-H that the minimum required frequency must consists of two evacuation drills for employees twice per year per shift with at least one evacuation every other month. Survey staff also clarified that third shift must also perform evacuation drills.

On November 15, 2022, at approximately 4:30 p.m., the M-H acknowledged the above findings.

No further information was provided.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

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0 970	Continued From page 14	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all one hundred fifty-five (155) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On November 15, 2022, at 10:15 a.m., during review of licensee's assisted living contract, it was noted the licensee's assisted living contract included limitation of liability for the resident's pendant notification system including, " to the maximum extent permitted by applicable law, in no event and under no legal theory shall The Waters Senior Living, it's owners, employees	0 970		

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0 970	Continued From page 15 and/or agents be liable to you or any other person for any general, direct, indirect, special, incidental, consequential, cover or other damages of any character arising out of the provision or use of the notification pendant, including but not limited to, personal injury or death, failure of the notification pendant to operate with any other programs, or any and all other damages or losses of whatever nature, even if The Waters Senior Living has been informed of the possibility of such damages." Furthermore, the licensee's assisted living contract included a waiver and release of all claims and assumption of risk, which stated, " please read this form carefully and be aware that in signing up and participating in any Waters program/activity, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of participating in any and all activities associated with The Waters Wellbeing Center." On November 15, 2022, at 12:18 p.m., senior director of health and wellbeing, compliance, and integrity (SDCI)-G confirmed the above findings and stated the same assisted living contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 16 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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topics:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;
(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for one of two employees (unlicensed personnel (ULP)-F.

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-F began providing assisted living services on November 2, 2018.

ULP-F's record lacked evidence annual training had been completed as required in the following

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01500	Continued From page 18 areas: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 15, 2022, at 2:50 p.m., senior living director of health and wellbeing (SLD)-A stated annual training was assigned through an online program, and verified annual training had not been completed for 2021. The licensee's Orientation and Annual Training Requirements policy dated April 2021, verified all licensee employees "that perform direct services will complete a minimum of 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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individualized medication management record for each resident based on the resident's assessment that must contain the following:
(1) a statement describing the medication management services that will be provided;
(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
(3) documentation of specific resident instructions relating to the administration of medications;
(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
(5) identification of medication management tasks that may be delegated to unlicensed personnel;
(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to ensure an individualized medication management plan included all the

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required content for one of five residents (R7).

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:

During the entrance conference on November 14, 2022, at approximately 10:00 a.m., senior regional director of health and wellbeing (SLD)-D confirmed the licensee provided medication management services to residents.

R7's service plan dated November 10, 2022, indicated R7 received medication management, oxygen management services, catheter care, and assistance with application and removal of TED (anti-embolism) stockings.

R7's record lacked evidence of a medication management plan to include:
- a statement describing the medication management services to be provided;
- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
- documentation of specific resident instructions relating to the administration of medications;
- identification of persons responsible for monitoring medication supplies and ensuring mediation refills were ordered on a timely basis;
- identification of medication management tasks that may be delegated to ULP;

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01730	Continued From page 21 - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On November 15, 2022, at 8:50 a.m., interim memory care director of health and wellbeing (IMCD)-B stated R7 was recently admitted to hospice and a medication management plan for R7's hospice medications had not been developed. The licensee's Individualized Medication Management Plan policy dated September 13, 2021, verified the licensee "will develop and maintain a current individualized medication management record for each resident," and would include the above required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01940		

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individualized treatment and therapy management record for each resident which must contain at least the following:
(1) a statement of the type of services that will be provided;
(2) documentation of specific resident instructions relating to the treatments or therapy administration;
(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure an individual treatment management plan contained all the required content, for one of five residents (R7).

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).

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The findings include:

During the entrance conference on November 14, 2022, at approximately 10:00 a.m., senior regional director of health and wellbeing (SLD)-D confirmed the licensee provided treatment management services to the residents.

R7's service plan dated November 10, 2022, indicated R7 received catheter care, and assistance with application and removal of TED (anti-embolism) stockings.

Prescriber's orders, dated June 1, 2022, included "foley catheter cares empty and clean as needed." In addition, the orders included "compression stockings-apply to bilateral lower extremities during the day and off at bed time."

R7 lacked an Individualized Treatment Therapy Management Plan that included the following:
-a statement of the type of services that would be provided
-documentation of specific resident instructions relating to the treatment or therapy administration
-identification of treatment or therapy tasks that would be delegated to unlicensed personnel;
-procedures for notifying a nurse or appropriate licensed health professional when a problem arose with the treatments or therapy services; and
-any resident-specific requirements relating to documenting of treatment and therapy received' verification all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.

On November 15, 2022, at 8:50 a.m., registered

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01940	Continued From page 24 nurse (RN)/interim memory care director of health and wellbeing (IMCD)-B confirmed an Individualized Treatment and Therapy Plan had not been developed or implemented for R7 as required. The licensee's Individualized Treatment & Therapy Management Plan policy dated September 13, 2021, indicated, "Each resident receiving management of ordered or prescribed treatments or therapy services, the [licensee] must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
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 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the	02040		

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licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and 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 November 15, 2022, at approximately 4:00 p.m., survey staff received and reviewed the facility's hazard vulnerability assessment plan, undated, Kaiser Permanente Assessment. At approximately 4:30 p.m., document review and interview with the M-H indicated the following:

1) The licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the undated Kaiser Permanente Assessment documentation did not include site-specific safety risks inside and outside of the property to protect the memory care residents from potential harm.

2) The plan documentation did not include mitigations to protect memory care residents from harm. Prevention measures to mitigate risks from

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THE WATERS OF EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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02040	Continued From page 26 the identified potential hazard and vulnerability assessment must be developed and documented in the plan. On November 15, 2022, at approximately 4:30 p.m., survey staff discussed the findings and explained to the M-H that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The M-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide care and services according to the acceptable health care medical or nursing standards to ensure safe storage of oxygen for one of one residents (R7) with oxygen. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30812	A. BUILDING: ______ B. WING ______	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDEN PRAIRIE	431 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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
02310	Continued From page 27 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: R7's service plan dated November 10, 2022, indicated R7 received oxygen, as needed for shortness of breath. Prescribers orders, dated November 9, 2022, included "oxygen 1L [liter] via nasal cannula-For shortnes [sic] of breath. May increase to 2L as needed if 1L does not improve shortness of breath-PRN [as needed] indicated for Shortness of breath." On November 15, 2022, at 8:50 a.m., the surveyor entered R7's apartment and observed one oxygen cylinder secured in a oxygen stand. Another oxygen cylinder was in the corner of the room not securely stored in a holder or stand. On November 15, 2022, at 2:50 p.m., senior living director of health and wellbeing (SLD)-A verified oxygen cylinders should be securely stored in a holder. The licensee's undated Oxygen Management form verified "can be dangerous if allowed to fall over-if damaged, the cylinder can act as a rocket, causing significant structural damage, potential injuries to person, and explosions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *11/15/22*
Time: 11:56:25
Report: 8058221229

Food and Beverage Establishment Inspection Report

Location:
The Waters Of Eden Prairie
431 Prairie Center Drive
Eden Prairie, MN55344
Hennepin County, 27

Establishment Info:
ID #: 0039292
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528289500
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.

2-300 Personal Cleanliness

2-301.14B-G ** Priority 1 **

MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.

EMPLOYEE OBSERVED HANDLING CLEAN DISHES AFTER LOADING DIRTY DISHES WITHOUT WASHING HAND BETWEEN CHANGING TASKS - COS

Comply By: 11/15/22

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(2) ** Priority 1 **

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

RAW GROUND BEEF HELD ABOVE FISH - CORRECTED ON SITE

Comply By: 11/15/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

BAKED POTATOES ON RACK KEPT OUT OF COOLER 68 DF - DISCARDED

Food and Beverage Establishment Inspection Report

Comply By: 11/15/22

3-800 Highly Susceptible Populations

3-801.11C ** Priority 1 **

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

RAW SHELLED EGGS SERVED NOT FULLY COOKED (RUNNY YOKE) - SEE COMMENTS

Corrected on Site

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

DISCONTINUE FOOD COOLING IN DEEP COVERED PANS - MONITOR THE COOLING PROCESS

Comply By: 11/16/22

2-400 Hygenic Practices

2-401.11A

MN Rule 4626.0105A Employees must not eat or use tobacco in food preparation or utensil washing areas.

EMPLOYEE OBSERVED DRINKING FROM CUP WHILE PLATING FOOD - COS

Comply By: 11/15/22

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

SMALL PAN OF BAKED POTATOES

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: SALMON
Temperature: 150 Degrees Fahrenheit - Location: COOKED
Violation Issued: No

Process/Item: SOUP
Temperature: 137 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: IM. CRAB TOAST
Temperature: 138 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: POTATO
Temperature: 68 Degrees Fahrenheit - Location: SHEET PAN
Violation Issued: Yes

Process/Item: EGG
Temperature: 41 Degrees Fahrenheit - Location: COLD PREP
Violation Issued: No

Process/Item: SHRIMP
Temperature: 39 Degrees Fahrenheit - Location: DRAWER PREP
Violation Issued: No

Process/Item: SOUP
Temperature: 170 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	1	2

STANDARDIZATION INSPECTION:

MDH: AARON GERTZ, JAMES NOYOLA
HRD: RHONDA MAKELA
ESTAB: KELLIE WIELAND BOHLIG

*NOTE:
RAW SHELLED EGGS CANNOT BE SERVED PARTIALLY COOKED (E.G. RUNNY) OR POOLED IN LARGE QUANTITIES BEFORE BEING USED (SUCH AS IN SCRAMBLED EGGS) UNLESS PASTEURIZED EGGS ARE USED

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 8058221229 of 11/15/22.

Certified Food Protection Manager: KELLIE WIELAND BOHLIG

Certification Number: 108176 Expires: 10/15/24

Inspection report reviewed with person in charge and emailed.

Signed:
KELLIE WIELAND BOHLIG
MANAGER

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