Electronically Delivered

March 2, 2022

Administrator
Inver Grove Heights White Pine
9058 Buchanan Trail
Inver Grove Heights, MN 55077

RE: Project Number(s) SL27378015

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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

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 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
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
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27378015 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 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.	

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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 January 19, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	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 record review and interview, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 630		

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0 630	Continued From page 3 The findings include: R1, R3, and R4's records lacked individualized abuse prevention plans to include statements of the specific measures to be taken to minimize the risk of abuse to that person. R1's diagnoses included cognitive impairment. R1's record did not include an individual abuse prevention plan. R3's diagnoses included cognitive impairment. R3's record did not include an individual abuse prevention plan. R4's diagnoses included Lewy body dementia. R4's record did not include an individual abuse prevention plan. On January 19, 2022, at 2:00 p.m. registered nurse (RN)-E confirmed the computer program used by the licensee for resident assessments did not include an individual abuse prevention plan with the required content. The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, directed the licensee to develop and implement and individual abuse prevention plan for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post an emergency plan prominently and develop an emergency preparedness plan with all required content. This had the potential to affect all 38 residents, staff and visitors. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 5 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: On January 18, 2022, at approximately 11:30 a.m., the surveyor observed no signage or information posted regarding the licensee's emergency plan. On January 20, 2022, at approximately 2:00 p.m., the surveyor reviewed the licensee's emergency preparedness plan and components with licensed assisted living director (LALD)-C. LALD-C verified the licensee's emergency preparedness plan had not been completed. LALD-C also confirmed the emergency plan was not prominently posted in the facility and explained that she thought this posting was not necessary because the residents were cognitively impaired and could not comprehend the posting. The licensee's plan lacked the following required content: -Emergency preparedness training and testing program; -Emergency preparedness training program for staff (including documentation of training provided) The licensee's policy, Appendix Z policy, dated March 26, 2021 indicated the licensee's emergency preparedness program would include training and testing.	0 680		

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0 680	Continued From page 6 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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0 730	Continued From page 7	0 730		

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 record review and interview, the licensee failed to ensure the client record included a discharge summary for one of one discharged resident (R2) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R2 was discharged on October 7, 2021.

R2's record lacked evidence a discharge summary was completed.

On January 20, 2022, at approximately 11:10 am registered nurse (RN)-A confirmed a discharge

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0 730	Continued From page 8 summary had not been completed for R2. A discharge policy was requested, but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include:	0 800		

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0 800	Continued From page 9 On January 19, 2022, from approximately 9:40 a.m. to 10:45 a.m., survey staff toured the facility with maintenance staff (MS)-F. During the facility tour, survey staff observed an obstructed sprinkler head in the second-floor nurse storage room and second-floor linen storage room. MS-F verbally confirmed survey staff observations during the facility tour. MS-F stated they will be removing the top shelf in each storage area to avoid obstructing the sprinkler heads in the future. 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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0 810	Continued From page 10 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 19, 2022, at approximately 11:00 a.m., the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, if available. Upon review the following items were not	0 810		

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0 810	Continued From page 11 documented: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. House Manager (HM)-D and Licensed Assisted Living Director (LALD)-C confirmed documentation of fire safety and evacuation policy and procedures were incomplete. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	01620		

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01620	Continued From page 12 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: Based on record review and interview, the licensee failed to ensure the registered nurse (RN) completed a reassessment as required, no later than 14 days after initiating services, for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 initial RN assessment was dated December 9, 2021. R1's following RN reassessment was dated January 10, 2022, 31 days after initiation of services.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 13 R1 was admitted to home care services at the assisted living facility on December 10, 2021. R1's diagnoses included cognitive impairment. R1's service plan dated December 10, 2021, indicated the resident received services to include medication management, personal hygiene, grooming, meal preparation, laundry and housekeeping. On January 19, 2022, at approximately 2:00 p.m. RN-E confirmed R1's reassessment had not been completed within 14 days, as required. The licensee's Assessment, Reviews, and Monitoring policy date August 1, 2021, directed a resident reassessment and monitoring be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

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INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

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01730	Continued From page 14 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 record review and interview, the licensee failed to develop an individualized medication management plan with the required content for two of three residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

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01730	Continued From page 15 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: R1's diagnoses included cognitive impairment. R1's Service plan, dated December 10, 2021, indicated the resident received medication management services. R1's prescriber orders dated January 20, 2022, included but were not limited to: sleep medication, anti-anxiety medication, calcium supplement, and dementia medication. R3's diagnoses included cognitive impairment. R3's Service plan dated August 29, 2021, indicated the resident received medication management services. R3's prescriber orders dated January 20, 2022, included but were not limited to: insulin, oral diabetic medication, glaucoma eye drops, and esophageal reflux medication. R1 and R3 lacked a medication management plan to include required content noted below: - a statement describing the medication management services that was 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;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

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01730	Continued From page 16 -identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis; -identification of medication management tasks that was delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On January 20, 2022, at approximately 11:00 a.m. registered nurse (RN)-G confirmed R1 and R3 lacked evidence of a medication management plan to include the above noted content. RN-G stated the computer program used by the licensee did not include a medication management plan form. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, directed the licensee prepare a written statement of medication management services for all residents receiving medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

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INVER GROVE HEIGHTS WP II LLC	9058 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

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01890	Continued From page 17 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an opened medication was dated correctly for one of four residents (R5) 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: On January 20, 2022, at approximately 10:00 a.m., surveyor observed registered nurse (RN)-A prepare to give Artificial Tears eye drops to R5. The bottle lacked an opened on date. RN-A verified the eye drops should have been dated when opened. According to manufacturers instructions the package insert recommends discontinuing use of the product after 90 days. A policy regarding labeling and dating of opened medication was requested, but not provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27378	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 18 days	01890		
01940 SS=F	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 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 record review and interview, the	01940		

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	27378	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 19 licensee failed to develop an individualized treatment management plan with the required content for two of three residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R1's diagnoses included cognitive impairment. R1's service plan, dated December 10, 2021, indicated the resident received management of prescribed treatment services. R1's prescriber orders, dated January 20, 2022, included compression stockings applied in the morning and removed at bedtime. R3's diagnoses included cognitive impairment. R3's service plan, dated July 29, 2021, indicated the resident received management of prescribed treatment services. R3's prescriber orders dated January 20, 2022, included blood glucose checks two times a day. R1 and R3 lacked a treatment management plan to include required content noted below: -a statement of the type of services that were provided; - documentation of specific resident instructions relating to the treatments or therapy	01940		

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	27378	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 20 administration; - identification of treatment or therapy tasks that were delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services; and -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. On January 20, 2022, at approximately 11:00 a.m., registered nurse (RN)-G confirmed R1 and R3 lacked evidence of a treatment management plan to include the above noted content. RN-G stated the computer program used by the licensee did not include a treatment management plan form. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, directed the licensee prepare a written statement of treatment or therapy management services for all residents receiving treatment or therapy management services. 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	02040		

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	27378	A. BUILDING: _____ B. WING _____	01/20/2022

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02040	Continued From page 21	02040		

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 interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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 residents).

The findings include:

On January 19, 2022, at approximately 11:15 a.m., during record review, the licensee failed to provide evidence of a completed hazard vulnerability assessment.

On January 19, 2022, at approximately 11:30 a.m., during the interview with the House Manager (HM)-D, the Licensed Assisted Living Director (LALD)-C, and maintenance staff (MS)-F, all three stated the facility had not yet

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02040	Continued From page 22 fully developed the required hazard vulnerability assessment. Global issues such as fire, gas leak, epidemic, and active shooter had been identified. Local hazards that are site, building, and population-specific had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *01/19/22*
Time: 10:54:57
Report: 7958221008

Food and Beverage Establishment Inspection Report

Location:
Inver Grove Heights White Pine
9058 Buchanan Trail
Inver Grove Heights, MN55075
Dakota County, 19

Establishment Info:
ID #: 0024685
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Inver Grove Heights WPII, LLC

Phone #: 6514556549
ID #: 31711

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

The following orders were issued during this inspection.

2-100 Supervision

2-103.11B ***** Priority 2 *****

MN Rule 4626.0035B The person in charge must ensure only authorized persons are permitted in food preparation, food storage, and warewashing areas of the establishment.

DURING THIS INSECTION, OTHERS OCCASIONALLY ENTERED KITCHEN. I ASKED KITCHEN MGR. IF THEY WERE INVOLVED WITH FOOD PREP SERVICES. SHE SAID NO. ENSURE ONLY THOSE ASSOCIATED WITH FOOD SERVICES OR EQUIPMENT MAINTENANCE ENTER KITCHEN AS REQ. BY ABOVE RULE.

Comply By: 01/19/22

Surface and Equipment Sanitizers

Wash temperature gauge: = at 154 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Final rinse temperature ga: = at 182 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Utensils surface temperatu: = at 163.2 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Ambient air temperature: = at 8 Degrees Fahrenheit
Location: Arctic Air single door freezer
Violation Issued: No

Ambient air temperature: = at 36 Degrees Fahrenheit
Location: Maximum single door refrigerator
Violation Issued: No

Ambient air temperature: = at 13 Degrees Fahrenheit
Location: Maximum double door freezer (Bulk storage
Violation Issued: No

Ambient air temperature: = at 36 Degrees Fahrenheit
Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Quaternary ammonium: = 2+ ppm at Degrees Fahrenheit
Location: Wiping cloth bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 37 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Ham loaf
Temperature: 36 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Hd boiled eggs
Temperature: 38 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Sour cream
Temperature: 37 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Cheese slices
Temperature: 37 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Bagged lettuce
Temperature: 38 Degrees Fahrenheit - Location: Maximum double door refrigerator (Bulk storage
Violation Issued: No

Process/Item: Cold Hold/Chix patties
Temperature: 38 Degrees Fahrenheit - Location: Maximum single door refrigerator
Violation Issued: No

Process/Item: Cold Hold/Deli meats
Temperature: 37 Degrees Fahrenheit - Location: Maximum single door refrigerator
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 38 Degrees Fahrenheit - Location: Maximum single door refrigerator
Violation Issued: No

Type: Full
Date: *01/19/22*
Time: 10:54:57
Report: 7958221008
Inver Grove Heights White Pine

Food and Beverage Establishment Inspection Report

Process/Item: Hot Hold/Sloppy Joe
Temperature: 144 Degrees Fahrenheit - Location: Stove top
Violation Issued: No

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

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT A FOOD SERVICE ESTABLISHMENT.

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

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE DISH MACHINE WAS MEASURED AT 163.2 DEGREES F., WHICH IS ABOVE THE MINIMUM UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F THAT IS REQUIRED BY THE MINNESOTA FOOD CODE. AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

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 7958221008 of 01/19/22.

Certified Food Protection Manager: Jodi Moe

Certification Number: FM90238 Expires: 07/24/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jodi Moe
Kitchen Mgr.

Signed: _____
George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us