STATE LICENSING COMPLIANCE REPORT

Report #: HL32917001C

Date Concluded: October 14, 2021

Name, Address, and County of Facility Investigated:
The Waters of White Bear Lake
3820 Hoffman Road
White Bear Lake, MN 55110
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lissa Lin, RN

Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144 and 144A. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32917	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF WHITE BEAR LAKE	3820 HOFFMAN ROAD WHITE BEAR LAKE, MN 55110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G., the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On October 7, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL32917001C. At the time of the survey, there were #57 clients/residents receiving services under assisted living license. The following correction order is issued for #HL32917001C, tag identification 0510.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 facility failed to establish and maintain an infection control program that complies with accepted healthcare, medical and nursing standards of infection. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This had the potential to effect all 114 residents in the facility, all visitors and all employees. The findings include: Personal Protective Equipment (PPE) The COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated June 30, 2021, indicated healthcare workers	0 510		

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0 510	Continued From page 2 (HCW) with face-to-face contact with COVID-19 negative residents need to wear a medical grade, well fitting face mask and eye protection. HCW with periodic face-to-face contact with residents (e.g. kitchen, environmental services, office) need to wear a medical-grade well fitting facemask. The MDH COVID-19 Guidance: long term care indoor visitation for nursing facilities and assisted living-type settings, dated May 20, 2021, indicated all long term care providers should continue to follow basic core principles for preventing COVID-19 infection, including: screening all who enter the setting for signs and symptoms of COVID-19; wearing a well-fitting facemask that fully covers the nose and mouth in accordance with CDC guidance; staff wear face masks and other needed PPE. The facility failed to ensure all staff wore face masks and/or eye protection while working. During an observation on October 7, 2021, at 9:15 a.m., a staff member seated at the front desk, Active Life Coordinator (AL-A) wore a face mask but no eye protection as she stood less than 6 feet from the MDH investigator during COVID-19 screening and log in on the paperless Accushield sign-in kiosk. During an observation on October 7, 2021, from 11:15 a.m. to 11:20 a.m., a cook (C-F) chopped foods wearing his face mask tucked under his chin which exposed his mouth and nose. C-F entered a walk-in cooler and came out with his face mask pulled up over his mouth but still exposed his nose and resumed preparing food. During an observation on October 7, 2021, at	0 510		

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0 510	Continued From page 3 11:45 a.m. server (S-I) walked around a hallway corner toward the MDH investigator with her mask down below her nose. S-I adjusted the mask over her nose when she saw the MDH investigator. During an interview on October 7, 2021 at 11:20 a.m. unlicensed personnel (ULP-H) said he was trained on wearing masks and eye protection all the time. ULP-H's mask was below his nose during the interview. A resident's unmasked family member approached ULP-H and stood less than 6 feet from him and asked care questions for several minutes. During an interview on October 7, 2021, at 11:45 a.m., S-I said all staff need to wear their masks up over their faces, wear their long hair up, wear PPE glasses all the time. S-I said some of the chefs wear their masks down below their noses or under their chins while working. During an interview on October 7, 2021 at 2:10 p.m., culinary director (CD-K) said "C-F is her number one offender" concerning PPE. CD-K said he is new and is reminded often about wearing PPE appropriately. CD-K said C-F went home at noon. Review of the culinary schedule for October 7 indicated C-F was scheduled to work 10:00-6:30 but 6:30 was crossed out and replaced with 11:30. During an interview on October 7, 2021 at 2:53 p.m., executive director (ED-B) said all staff should wear mask and goggles in common areas and for direct cares. During an interview on October 7, 2021 at 2:53 p.m., Senior Director of Health and Well Being (SD-M) said masks and goggles need to be worn	0 510		

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0 510	Continued From page 4 everywhere. Review of a policy and procedure titled Procedure for Donning and Doffing Masks, dated May 25, 2021, indicated masks are to be worn whenever there may be a transfer of contaminated microorganisms from one individual to another through the respiratory tract or in situations when there may be splashing of contaminated material. Make sure the mask fits snugly well under the chin; gently punch [sic] upper metal bank around bridge of nose. Review of a policy titled Eye Protection Guidance for Team Members, 6-25-21 updated MN only, indicated use of eye protection for team members who provider direct resident care or who interact or provide services at a distance of less than six feet. COVID-19 Screening The facility failed to ensure all staff entering the building performed temperature checks and answered COVID-19 screening questions before starting work. During a facility tour with executive director (ED-B) at 9:35 a.m. on October 7, 2021, ED-B said there are some staff who do not use the main entrance but come in through another door on the main floor. ED-B said staff should use the main entrance, it was reviewed a week earlier, but there are still staff coming in through the side door. There is no COVID-19 screening station at the other door. Staff have been instructed to go to the front desk and get screened before starting their work shift but there is no way to enforce that. Review of an email titled Good Afternoon Team,	0 510		

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0 510	Continued From page 5 undated, indicated an all staff meeting was scheduled for September 30, 2021 at 2:30 p.m. One of the topics was signing in - staff need to sign in and out at the kiosk at the front concierge desk and enter through the front door only. Review of the Accushield sign in log report for October 7, 2021 at approximately 2:45 p.m. indicated five staff members failed to sign in and COVID-19 screen (temperature check and answer screening questions) before starting work: ULP-H, ULP-N, CD-K, C-O and S-I. During an interview on October 7, 2021 at 1:30 p.m., DON-C said staff should use the main entrance but there is always a risk they may use another door and not check in at the front desk and screen for COVID. DON-C said she does not check the Accushield sign in log, someone like the concierge should check the logs. During an interview on October 7, 2021 at 2:53 p.m., executive director (ED-B) said there are many new staff at the facility and some tasks need to be assigned, they are working on that. ED-B has not reviewed the Accushield COVID-19 sign in logs for compliance. Review of a policy titled Team Member Screening for COVID-19, undated, indicated the first priority is the safety, health and well-being of the residents and team members. The facility requires all team members to complete screening for COVID-19 symptoms upon arrive [sic] to work each day. No further information provided. TIME PERIOD TO CORRECT: Two (2) Days	0 510		