DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 28, 2022

Administrator
Waters Edge Assisted Living
322 County Highway 6
Clinton, MN 56225

RE: Project Number(s) SL30340015

Dear Administrator:

On September 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 27, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

August 19, 2022

Administrator
Waters Edge Assisted Living
322 County Highway 6
Clinton, MN 56225

RE: Project Number(s) SL30340015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up 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:	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

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

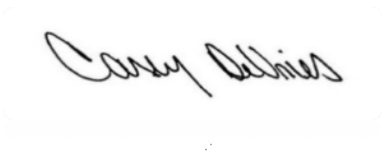
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30340	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE ASSISTED LIVING	322 COUNTY HIGHWAY 6 CLINTON, MN 56225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30340015-0 On July 25, 2022, through July 27, 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 15 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on July 27, 2022, issued for SL30340015-0, tag identification 2310. On July 28, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 15 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of 22 residents and had a current census of 15 residents. During the entrance conference on July 25, 2022, at approximately 9:35 a.m., assisted living director in residency (ALDIR)-A stated the usual staffing schedule for the facility was as follows: - the registered nurse (RN) was available by phone with a schedule of who was on call in the nurse's office; - the day shift was scheduled with one unlicensed personnel (ULP) from 7:00 a.m., to 3:00 p.m.; - the evening shift was scheduled with one ULP from 3:00 p.m., to 11:00 p.m.; and - the night shift was scheduled with one ULP from 11:00 p.m., to 7:00 a.m. In addition, during the entrance conference, ALDIR-A stated they look at the number of residents and the number of cares to determine their staffing and had no written plan in use. The licensee's Staffing & Scheduling policy dated July 26, 2021, noted the clinical nurse supervisor or assisted living director would develop and implement a written staffing plan to provide an adequate number of staff to meet the residents' needs. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect the licensees 15 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 4 The findings include Upon entrance to the facility on July 25, 2022, at approximately 9:05 a.m., assisted living director in residency (ALDIR)-A escorted the surveyor through the main entrance to the dayroom. The surveyor observed ALDIR-A with a medical grade face mask, but no eye protection. At approximately 9:11 a.m., unlicensed personnel (ULP)-C entered the dayroom to talk with the surveyor wearing a medical grade face mask but no eye protection. When questioned by the surveyor, ULP-C stated she had not been instructed to wear eye protection. At 9:15 a.m., ALDIR-A stated eye protection was available at the front desk but stated staff were not wearing them. ALDIR-A stated the community level was low. On July 25, 2022, at approximately 11:55 a.m., the surveyor observed kitchen staff (K)-F serving food to residents in the dining room without a face mask or eye protection. At this time, ALDIR-A stated K-F typically did not come out of the kitchen and stated she should be wearing PPE when out near residents. On July 26, 2022, at approximately 7:30 a.m., the surveyor observed ULP-B exiting the medication room on her way to perform a blood glucose check on a resident. ULP-B was wearing a mask but no eye protection. ULP-B stated she had not been instructed to wear eye protection but did find them when informed where they were by the surveyor. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by	0 510		

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0 510	Continued From page 5 community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker for July 26, 2022, indicated the community transmission level for the licensee's county was high. The licensee's COVID-19 Management & Testing Plan policy dated July 26, 2021, noted the licensee would adhere to Federal and State/Local recommendations to include the use of eye protection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time	0 580		

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0 580	Continued From page 6 of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 15 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2022, at approximately 9:35 a.m., during the entrance conference with the assisted living director in residency (ALDIR)-A, the surveyor made a request to review documentation of the licensee's quality management activities. ALDIR-A stated she was aware they should be doing a quality management program, but had not started anything formal and had nothing documented. The licensee's Quality Management Project policy, undated, noted the licensee would have at least one documented quality management project in place at all times, and would retain the records for at least two years. No further information was provided.	0 580		

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0 580	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment and the 911 emergency number as required. This had the potential to affect all 15 current 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	0 640		

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0 640	Continued From page 8 of the residents). The findings include: On July 25, 2022, at approximately 10:30 a.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-A and noted no posting for the contact information for Minnesota Adult Abuse Reporting Center (MAARC) or 911 emergency number. ALDIR-A confirmed during the tour, the required content was not posted. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated July 26, 2022, noted the licensee would post the 911 emergency number in common areas and near telephones provided by the licensee, and would post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 9 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for three of three employees (assisted living director in residency (ALDIR)-A, registered nurse (RN)-E and unlicensed personnel (ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 650		

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0 650	Continued From page 10 The findings include: ALDIR-A ALDIR-A was hired under the comprehensive home care license on June 25, 2021, and began providing assisted living services on August 1, 2021. ALDIR-A's employee record lacked evidence of: - records of orientation, infection control training and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. RN-E RN-E was hired to provide assisted living services on February 16, 2022. RN-E's employee record lacked evidence of: - records of orientation and infection control training; and - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-B ULP-B was hired under the comprehensive home care license on December 27, 2020, and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of: - records of orientation, infection control training and competency evaluations; - current job description, including qualifications,	0 650		

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	30340	A. BUILDING: _____ B. WING _____	07/27/2022

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0 650	Continued From page 11 responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 26, 2022, at approximately 2:45 p.m., ALDIR-A stated she had just started to go through the employee records to audit the content, and confirmed the records lacked the above required content. ALDIR-A stated they had moved into a new building and were still trying to get everything organized. In addition, ALDIR-A stated the orientation had been completed but was not available in the employee records. The licensee's Employee Records policy dated July 26, 2021, noted the employee records would include records of all training and in-service education including competency testing as required, a current job description including qualifications, responsibilities, and identification of supervisors if any, documentation of annual performance reviews, and verification of completed orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 12 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completion of a facility risk assessment, documentation of a completed health history and symptom screening for three of three employees (assisted living director in residency (ALDIR)-A, registered nurse (RN)-E and unlicensed personnel (ULP)-B), and evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (RN-E and ULP-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 660		

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0 660	Continued From page 13 The findings include: On July 25, 2022, at approximately 9:35 a.m., during the entrance conference, assisted living director in residence (ALDIR)-A stated a facility risk assessment had not been completed. ALDIR-A ALDIR-A was hired under the comprehensive home care license on June 25, 2021, and began providing assisted living services on August 1, 2021. ALDIR-A's employee record contained evidence of a QuantiFERON (detects latent tuberculosis) blood test dated February 11, 2022; however, the record lacked: - evidence of a completed TB history and symptom screening as required. RN-E RN-E was hired to provide assisted living services on February 16, 2022. RN-E's employee record lacked evidence of the following: - documentation of a completed health history and symptom screening; and - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. ULP-B ULP-B was hired under the comprehensive home care license on December 27, 2020, and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of the following: - documentation of a completed health history	0 660		

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0 660	Continued From page 14 and symptom screening; and - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On July 27, 2022, at approximately 2:10 p.m., ALDIR-A stated in March 2022 she had provided the TB form from the Minnesota Department of Health website to complete the health screen and TB testing as required but had not received back from the above staff yet. The licensee's Tuberculosis Screening policy dated July 26, 2021, noted the facility would maintain a current community TB risk assessment, and staff screening would include screening for active signs of TB and have a two-step TST or blood test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 15	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 interview and record review, the licensee failed to develop a written emergency preparedness plan with all the required content. This had the potential to affect all 15 residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 16 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: During the entrance conference on July 25, 2022, at 9:35 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP). Assisted living director in residency (ALDIR)-A stated she was aware of the requirement to have the emergency plan but had not started working on it yet. The licensee's Emergency - Evacuation Report, dated July 5, 2022, listed the resident name, evacuation assistance required and assistive devices used. The licensee lacked an emergency preparedness plan to include the following: - a completed risk assessment; - policies and procedures to address natural and man-made disasters; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly; - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents;	0 680		

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0 680	Continued From page 17 - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families.	0 680		

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0 680	Continued From page 18 The licensee's Disaster Planning and Emergency Preparedness policy dated July 26, 2021, noted the licensee would have a general emergency preparedness plan to comply with Appendix Z. No further 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	0 730		

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0 730	Continued From page 19 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 20 R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R3's diagnoses included atrial fibrillation (irregular rapid heart rate). R3's progress note dated June 10, 2022, noted R3 was transferred to a skilled nursing facility. On July 25, 2022, at approximately 12:50 p.m., assisted living director in residency (ALDIR)-A stated she was aware of the requirements of the discharge summary, but the registered nurse in charge of it had left, and it had not gotten done. On July 27, 2022, at approximately 10:10 a.m., registered nurse (RN)-E stated she was familiar with the requirement of the discharge summary but not with the new regulations. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 21 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record 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.	0 810		

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0 810	Continued From page 22 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 July 25, 2022, from approximately 1:00 p.m. to 2:30 p.m., survey staff toured the facility with assisted living director in residency (ALDIR)-A and maintenance (M)-D. During the facility tour, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following. 1. Fire Safety Evacuation map was not posted or maintained. 2. Fire Safety evacuation plan did not show employee actions to be taken in the event of a fire or similar emergency. 3. Fire safety plans did not show fire protection procedures necessary for residents. 4. Documentation of required employee evacuation drills did not show drills being done every other month. 5. The schedule and required records on training of employees on fire safety and evacuation. 6. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, and relocation. On July 25, 2022, at approximately 2:30 p.m. ALDIR-A was not able to provide the information	0 810		

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0 810	Continued From page 23 listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.	0 900		

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0 900	Continued From page 24 (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of three 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, 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: R5's record lacked a written contract which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, R5's records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and	0 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 25 any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - offer the resident the opportunity to identify a designated representative. R5's diagnoses included dementia. The surveyor requested a copy of R5's contract, however assisted living director in residency (ALDIR)-A stated on July 27, 2022, at approximately 11:15 a.m., she was unable to locate the contract. R5 had not received a service plan from the licensee. However, R5's Residential Services Plan from the county dated May 21, 2022, noted services which included assistance with housekeeping, meals and medication management. The licensee's Signing and Assisted Living Contract policy dated July 26, 2021, noted when a prospective resident decides to move into the facility, a signed contract would be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name,	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30340	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE ASSISTED LIVING	322 COUNTY HIGHWAY 6 CLINTON, MN 56225

(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
0 910	Continued From page 26 telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all 15 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 the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include the following required content: - the name, telephone number and physical mailing address of the authorized agent for the facility. R1 R1's diagnoses included diabetes. R1's Plan of Care document for services, undated, and identified by assisted living director	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 910	Continued From page 27 in residency (ALDIR)-A as the service plan, noted services which included blood sugar testing and medication management. R1's contract dated August 3, 2022, signed by the resident, lacked the above required content. R2 R2's diagnoses included Parkinson's disease. R2's Plan of Care document for services, undated, noted services which included medication management and blood sugar testing. R2's contract dated September 15, 2021, signed by the resident, lacked the above required content. On July 26, 2022, at approximately 2:30 p.m., ALDIR-A confirmed the contracts lacked the required content, and stated the same contract was utilized for all residents. The licensee's Signing and Assisted Living Contract policy dated July 26, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an	0 920		

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0 920	Continued From page 28 assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all 15 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 the potential to affect a large portion or all the residents). The findings include:	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 29 The licensee failed to provide a contract to include the following required content: - a disclosure that it does not hold an assisted living facility with dementia care license. R1 R1's diagnoses included diabetes. R1's Plan of Care document for services, undated, and identified by assisted living director in residency (ALDIR)-A as the service plan, noted services which included blood sugar testing and medication management. R1's contract dated August 3, 2022, signed by the resident, lacked the above required content. R2 R2's diagnoses included Parkinson's disease. R2's Plan of Care document for services, undated, noted services which included medication management and blood sugar testing. R2's contract dated September 15, 2021, signed by the resident, lacked the above required content. On July 26, 2022, at approximately 2:30 p.m., ALDIR-A confirmed the contracts lacked the required content, and stated the same contract was utilized for all residents. The licensee's Signing and Assisted Living Contract policy dated July 26, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 30 (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all 15 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	0 930		

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0 930	Continued From page 31 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: The licensee failed to provide a contract to include the following required content: - a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints; - the right under section 144G.54 to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility under which resident consent is required for a transfer. R1 R1's diagnoses included diabetes. R1's Plan of Care document for services, undated, and identified by assisted living director in residency (ALDIR)-A as the service plan, noted services which included blood sugar testing and medication management. R1's contract dated August 3, 2022, signed by the resident, lacked the above required content. R2 R2's diagnoses included Parkinson's disease. R2's Plan of Care document for services, undated, noted services which included medication management and blood sugar testing. R2's contract dated September 15, 2021, signed	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 930	Continued From page 32 by the resident, lacked the above required content. On July 26, 2022, at approximately 2:30 p.m., ALDIR-A confirmed the contracts lacked the required content, and stated the same contract was utilized for all residents. The licensee's Signing and Assisted Living Contract policy dated July 26, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	0 940		

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0 940	Continued From page 33 time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1 and R2) with records reviewed. This had the potential to affect all 15 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 the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include the following required content: - whether the facility is enrolled with the commissioner of human services to provide	0 940		

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0 940	Continued From page 34 customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the contact information to obtain long-term care consulting services under section 256B.0911. R1 R1's diagnoses included diabetes. R1's Plan of Care document for services, undated, and identified by assisted living director in residency (ALDIR)-A as the service plan, noted services which included blood sugar testing and medication management. R1's contract dated August 3, 2022, signed by the resident, lacked the above required content.	0 940		

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0 940	Continued From page 35 R2 R2's diagnoses included Parkinson's disease. R2's Plan of Care document for services, undated, noted services which included medication management and blood sugar testing. R2's contract dated September 15, 2021, signed by the resident, lacked the above required content. On July 26, 2022, at approximately 2:30 p.m., ALDIR-A confirmed the contracts lacked the required content, and stated the same contract was utilized for all residents. The licensee's Signing and Assisted Living Contract policy dated July 26, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 36 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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	01470		

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01470	Continued From page 37 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 employees received orientation to assisted living licensing requirements and regulations prior to providing services for three of three employees (assisted living director in residency (ALDIR)-A, registered nurse (RN)-E and unlicensed personnel (ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ALDIR-A, RN-E and ULP-B's records lacked documented evidence of the following: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470		

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01470	Continued From page 38 - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Offices of the Ombudsman for Mental Health and Developmental disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. ALDIR-A ALDIR-A was hired under the comprehensive home care license on June 25, 2021, and began providing assisted living services on August 1, 2021. ALDIR-A's employee record lacked evidence of the above required orientation content. RN-E RN-E was hired to provide assisted living services on February 16, 2022. RN-E's employee record lacked evidence of the above required orientation content. ULP-B ULP-B was hired under the comprehensive home care license on December 27, 2020, and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of the above required orientation content.	01470		

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01470	Continued From page 39 On July 26, 2022, at approximately 2:45 p.m., ALDIR-A stated no training had been provided to any staff on the new statutes or policies related to the changes effective August 1, 2021, to include the above required content. The licensee's Employee General Orientation policy dated July 26, 2021, noted upon hire and prior to performing any functions of their position, each employee would be oriented in accordance with State and Federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01530		

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WATERS EDGE ASSISTED LIVING	322 COUNTY HIGHWAY 6 CLINTON, MN 56225

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01530	Continued From page 40 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (assisted living director in residency (ALDIR)-A, registered nurse (RN)-E and unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living license. During the entrance conference on July 25, 2022, at approximately 9:35 a.m., ALDIR-A stated the licensee did not have a secure dementia unit, but did provide services to residents with the diagnosis of dementia. ALDIR-A	01530		

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01530	Continued From page 41 ALDIR-A was hired under the comprehensive home care license on June 25, 2021, and began providing assisted living services on August 1, 2021. ALDIR-A's employee record lacked evidence of the following required dementia care training: - an explanation of Alzheimer's disease and other dementias; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. RN-E RN-E was hired to provide assisted living services on February 16, 2022. RN-E's employee record lacked evidence of the following required dementia care training: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. ULP-B ULP-B was hired under the comprehensive home care license on December 27, 2020, and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of the following required dementia care training: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery.	01530		

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01530	Continued From page 42 On July 26, 2022, at approximately 2:45 p.m., ALDIR-A verified no staff had received training in Alzheimer's disease and other dementias as required. The licensee's Dementia Training policy dated July 26, 2021, noted staff would complete the required amount of training to include an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 43 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 90 days after the last assessment for one of two 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, 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: R1's diagnoses included diabetes. R1's undated Plan of Care document indicated R1 received assistance with medication management and activities of daily living. R1's record contained an Assessment as of Date, dated March 28, 2022. However, R1's record lacked any further assessments.	01620		

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01620	Continued From page 44 On July 26, 2022, at approximately 2:05 p.m., ALDIR-A confirmed no assessment had been completed for R1 after March 28, 2022, stating the RN responsible for completing the assessments had left, and they were in the process of hiring a replacement. In addition, ALDIR-A stated the two RNs that remained were responsible for taking call and medication set-up, but had not completed any assessments. The licensee's Assessments, Reviews & Monitoring policy dated July 26, 2021, noted the monitoring and review cannot exceed 90 calendar days form the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

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01650	Continued From page 45 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 and R2's service plans lacked the following required content: - frequency of each service; - identification of staff or categories of staff who would provide the services; - schedule and methods of monitoring reviews or assessments of the resident; - schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 46 - a contingency plan that included the action to be taken if the scheduled service could not be provided. R1 R1's diagnoses included diabetes. R1's undated Plan of Care document, identified by assisted living director in residency (ALDIR)-A as the service plan, indicated R1 received assistance with medication management and activities of daily living, but lacked the above required content. R2 R2's diagnoses included Parkinson's disease. R2's undated Plan of Care, indicated the resident received assistance with blood sugar testing and medication administration, but lacked the above required content. On July 26, 2022, at approximately 2:05 p.m., ALDIR-A stated they were in the process of transferring to an electronic record system, but had not utilized the available service plan through that system or provided it to the residents. In addition, ALDIR-A confirmed the current form utilized as the service plan lacked the required content. The licensee's Service Plan policy dated July 26, 2021, noted the service plan would include the frequency of each service to be provided, an identification of staff or categories of staff who would be providing services, a schedule and methods for the next planned assessment or monitoring, a schedule and method for the next planned monitoring of staff providing services, and a contingency plan that included the actions	01650		

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01650	Continued From page 47 the licensee would take if scheduled services could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R2) observed with insulin administration via a prefilled insulin pen, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01760		

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01760	Continued From page 48	01760		

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

The findings include:

R2's insulin was not administered according to the manufacturer's instructions.

R2's undated Plan of Care, identified by assisted living director in residency (ALDIR)-A as the service plan, indicated R2 received blood sugar testing and medication administration.

R2's prescriber orders dated April 26, 2022, included Tresiba FlexTouch pen, 40 units under the skin every 24 hours.

R2's July 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given.

On July 26, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer insulin to R2. ULP-B dialed the Tresiba FlexTouch pen to 40 units and administered the insulin, without priming the pen. Upon exiting R2's room, ULP-B confirmed she did not prime the pen, and asked the surveyor what that meant. In addition, ULP-B stated she had not been trained to prime the insulin pen.

On July 26, 2022, at approximately 1:40 p.m., ALDIR-A stated she herself had not been trained to prime the insulin pen.

On July 27, 2022, at approximately 10:10 a.m.,

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01760	Continued From page 49 registered nurse (RN)-E stated she expected staff to prime the insulin pen before drawing up the prescribed amount. The manufacturer's instruction for the use of Tresiba FlexTouch pen dated September 2015 instructed to prime the pen by turning the dose selector to 2 units, pressing and holding the dose button until the counter shows 0, before turning the dose to the prescribed dose. The licensee's Insulin policy dated July 26, 2021, lacked instruction on priming the insulin pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 50	01790		

delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the

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01790	Continued From page 51 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on July 25, 2022, at approximately 9:35 a.m., assisted living director in residency (ALDIR)-A confirmed the licensee provided medication management services to residents. The licensee's Medication Management - Planned & Unplanned Time Away policy dated July 26, 2021, noted for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate the task to the unlicensed personnel if the RN had developed written procedures to address: - the type of container or containers to be used for the medications appropriate to the provider's medication system;	01790		

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01790	Continued From page 52 - how the container or containers must be labeled; - the written information about the medications to be given to the resident or resident's representative; - how the ULP must document in the resident's record that medications had been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information; - how the RN should be notified that medications had been given to the resident or resident's representative and whether the RN needed to be contacted before the medications were given to the resident or resident's representative; - a review by the RN of the completion of this task to verify the task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication. On July 25, 2022, at approximately 11:35 a.m., ALDIR-A verified the above required written procedures were not available. On July 27, 2022, at approximately 10:10 a.m., registered nurse (RN)-E confirmed no written procedures were developed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for 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 medications were maintained bearing a prescription label with legible information and failed to date time sensitive medications with a date when opened for one of three residents (R2) with insulin, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 25, 2022, at approximately 9:35 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided medication management services to the licensee's residents. On July 26, 2022, at approximately 9:35 a.m., the surveyor completed a review of the licensee's	01890		

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01890	Continued From page 54 medication room in the presence of unlicensed personnel (ULP)-B, who confirmed the findings. R2's opened Tresiba FlexTouch insulin pen lacked a prescription label with the required information. In addition, the pen lacked a date to indicate when staff opened it, or when it would expire. ULP-B showed the surveyor R2's overflow Tresiba FlexTouch pens were in the refrigerator in a box, which was labeled, and contained 4 pens. The manufacturer's instruction for the use of Tresiba FlexTouch pen dated September 2015 indicated Tresiba lasts 56 days after opened. On July 27, 2022, at approximately 10:10 a.m., registered nurse (RN)-E confirmed the insulin pens should have a prescription label and should be dated when opened. The licensee's Insulin policy dated July 26, 2021, instructed to compare the information on the administration record and the label, and stated both should contain the resident name, name of the medication, strength and dosage of the medication, the route, time that the medication is to be given, and any special instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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	30340	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS EDGE ASSISTED LIVING	322 COUNTY HIGHWAY 6 CLINTON, MN 56225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 55 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 observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01940		

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01940	Continued From page 56	01940		

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 July 25, 2022, at approximately 9:35 a.m., assisted living director in residency (ALDIR)-A stated the licensee provided treatment management services to the licensee's residents.

R2's diagnoses included Parkinson's disease.

On July 26, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-B perform a blood glucose check on R2 in his room.

R2's undated Plan of Care, identified by assisted living director in residency (ALDIR)-A as the service plan, indicated the resident received assistance with blood sugar testing and medication administration. In addition, R2's service plan lacked a written statement of the treatment services being provided to include the specialized diet.

R2's Assessment as of Date dated May 11, 2022, noted R2 required liquids thickened to nectar thick and food cut into bite size pieces. It also noted R2 required assistance with blood sugar checks.

R2's July 2022 Service Recap Summary noted "Record - Blood Glucose" with a spot for staff to initials to indicate the service had been provided.

R2's records lacked a treatment management

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01940	Continued From page 57 plan to include: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatment 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 complications or adverse reactions. On July 26, 2022, at approximately 10:25 a.m., ALDIR-A confirmed the resident's record lacked a treatment management plan. On July 27, 2022, at approximately 10:10 a.m., registered nurse (RN)-E stated she was not aware of the requirement to develop a treatment management plan. On July 27, 2022, at approximately 12:00 p.m., ALDIR-A stated she was unable to locate signed orders for R2's specialized diet and blood glucose checks. A policy related to the content of a treatment management plan was requested but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 25, 2022, at approximately 9:35 a.m., assisted living director in residency (ALDIR)-A confirmed the licensee provided treatment services to the licensee's residents. R2's diagnoses included Parkinson's disease.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30340	A. BUILDING: _____ B. WING _____	07/27/2022

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01970	Continued From page 59 On July 26, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-B perform a blood glucose check on R2 in his room. R2's undated Plan of Care, identified by ALDIR-A as the service plan, indicated R2 received assistance with blood sugar testing and medication administration. R2's Assessment as of Date dated May 11, 2022, noted R2 required liquids thickened to nectar thick and food cut into bite size pieces. It also noted R2 required assistance with blood sugar checks. R2's July 2022 Service Recap Summary noted "Record - Blood Glucose" with a spot for staff to initials to indicate the service had been provided. R2's record lacked prescriber orders for daily blood glucose checks and a specialized diet to include nectar thickened liquids. On July 27, 2022, at approximately 10:10 a.m., registered nurse (RN)-E stated there should be prescriber orders for treatments. On July 27, 2022, at approximately 12:00 p.m., ALDIR-A stated she was unable to locate signed orders for R2's specialized diet and blood glucose checks. The licensee's Medications & Treatment Orders policy dated July 26, 2021, noted the RN was responsible to assure a current authorized prescriber orders for treatments administered by the staff were kept on file in the residents' records. No further information was provided.	01970		

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01970	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 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, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with a hospital bed with bedrails, and two of two residents (R1 and R5) with an assistive device. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This practice resulted in an immediate order for correction on July 27, 2022. The findings include: HOSPITAL BED	02310	On July 28, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	

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02310	Continued From page 61 R4 R4's diagnoses included hypertension. On July 27, 2022, at approximately 9:55 a.m., the surveyor measured R4's bedrails in the presence of assisted living director in residency (ALDIR)-A. R4's bed had a bedrail on the left side of the bed, in the raised position. The bedrail was a brown metal color, affixed to the hospital bed. The openings between the bars for zone 1 measured 3 1/4 inches. The measurements between the mattress and bedrail for zone 3, measured 0 inches. The measurements between the top of the rail and the headboard for zone 7, measured 2 1/2 inches. At this time, R4 stated she utilized the bedrail to help her get into bed. R4 had not received a service plan from the licensee. However, R4's Residential Services Plan from the county dated June 22, 2022, noted services which included assistance with activities of daily living and medication management. R4 had a signed contract with the facility dated June 6, 2022. R4's Individual Review dated June 22, 2022, lacked identification R4 utilized a bedrail. The review noted R4 was independent with bed mobility. R4's record did not contain evidence of a bedrail assessment. ASSISTIVE DEVICE R1 R1's diagnoses included diabetes. On July 26, 2022, at approximately 1:50 p.m., the surveyor measured R1's assistive device in the presence of ALDIR-A. R1's bed was a full-sized	02310		

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02310	Continued From page 62 mattress with a device on both sides of the bed. The right side had an upside-down U-shaped metal device, dark gray, that extended under the mattress 13 inches. The openings between the bars measured 17 inches, and there was a mesh cloth which enclosed the area. The second part of the device, which was attached to the first part by a hinge, was an upside-down U-shaped bar on the middle of the mattress and measured 13 1/2 inches horizontally between the bars. This portion was able to swivel out when R1 was getting in or out of bed and reached all the way to the floor on the lowest bar, and had a rubber stopper on the floor. The device on the left side of the bed extended under the mattress approximately 24 inches and measured 4 inches between the three bars vertically. Neither device was affixed to the bed. At this time, LALD-A stated R1 utilized her bed when she first came in but had not slept in her bed for a long time. R1's Plan of Care document for services, undated, and identified by ALDIR-A as the service plan, noted services which included blood sugar testing and medication management. R1's Assessment As Of Date, dated March 28, 2022, noted R1 had a "Standard bed frame" and "Mattress original to bed". The assessment lacked identification R1's bed had assistive devices. R1's record did not contain evidence of a bedrail assessment. On July 27, 2022, at approximately 8:45 a.m., ALDIR-A stated she had spoken with R1's family requesting the manufacturer name in order to look up the manufacturer installation instructions, but the family chose to remove the assistive devices since R1 was not sleeping in her bed.	02310		

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02310	Continued From page 63 On July 27, 2022, at approximately 12:55 p.m., R1 stated she used the devices to help her to turn in bed when she first came to the licensee. R1 stated she hadn't slept in the bed for some time as she preferred to sleep in her recliner now. R5 R5's diagnoses included dementia. On July 27, 2022, at approximately 10:00 a.m., the surveyor measured R5's assistive device in the presence of ALDIR-A. R5's bed was a hospital bed with an assistive device on the left side of the bed. The device was question mark shaped and attached to a board that measured approximately 18 inches by 24 inches between the mattress and the box spring. The board had a black strap approximately 1 inch wide going around the box spring. The 3/4 circle on the top of the device measured 12 inches horizontally and 6 inches vertically between the bar. The device measured 14 inches from the top of the device to the wall. The bed had no headboard and was tight to the wall. In addition, the open area of the device had a mesh cloth to enclose the opening. The surveyor requested a copy of R5's contract, however ALDIR-A stated on July 27, 2022, at approximately 11:15 a.m., she was unable to locate the contract. R5 had not received a service plan from the licensee. However, R5's Residential Services Plan from the county dated May 21, 2022, noted services which included assistance with housekeeping, meals and medication management. R5's Initial Review dated, May 18, 2022, lacked identification R5 utilized an assistive device. The	02310		

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02310	Continued From page 64	02310		

assessment indicated R5 was independent with bed mobility. R5's record did not contain evidence of a bedrail assessment.

On July 26, 2022, at approximately 1:45 p.m., ALDIR-A verified the assessments for R1, R4 and R5 lack identification of a bedrail or device, lacked a bedrail or assistive device assessment, and lacked a risk versus benefits review with the residents or their representatives.

On July 27, 2022, at approximately 10:10 a.m., the surveyor interviewed registered nurse (RN)-E via phone regarding the residents' bedrails and devices. RN-E stated she had not done an assessment on any of the three residents noted related to the use of bedrails or devices, or on how their cognitive or physical status, risk for falls, transfer ability, pain, or incontinence would be impacted by the use of a bedrail or device. RN-E stated she was aware of the need to educate about risks versus benefits but had not done so for any of the facility's residents related to the use of these devices. RN-E and ALDIR-A stated the RN who had completed the resident assessments had resigned.

On July 27, 2022, at approximately 1:25 p.m., ALDIR-A stated she reviewed the Consumer Product Safety Commission (CSPC) website to ensure the bedrail and assistive devices in use had not been recalled. However, ALDIR-A confirmed it had not been done prior. Additionally, on this date, ALDIR-A printed the manufacturer's installation instructions for R5's assistive device and verified it was installed properly.

The licensee's Side Rails policy dated July 26, 2021, noted when the licensee "is aware a home care resident is utilizing side rails (a medical

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02310	Continued From page 65	02310		

device) on a bed, Waters Edge Assisted Living will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail."

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information."

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems

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02310	Continued From page 66 with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE UPDATE: Upon supervisory review, the following sentence from R4's bedrail description is redacted as the FDA did not publish dimensional measurements for zones 5, 6, or 7: -The measurements between the top of the rail and the headboard for zone 7, measured 2 1/2 inches. The redaction of the above sentence bears no impact on the scope/severity of the citation issued.	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	03090		

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03090	Continued From page 67 Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 15 current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 of the residents). The findings include: On July 25, 2022, at approximately 10:30 a.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-A and noted no posting at the main entrance related to electronic monitoring as required. ALDIR-A stated she had the signs but had not yet posted them. The licensee's Electronic Monitoring policy dated July 26, 2021, noted signs would be installed at each entrance accessible to visitors that state "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *07/26/22*
Time: 12:30:21
Report: 1008221036

Food and Beverage Establishment Inspection Report

Location:
Waters Edge Assisted Living
322 County Highway 6
Clinton, MN56225
Big Stone County, 06

Establishment Info:
ID #: 0039372
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203255414
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 157 Degrees Fahrenheit - Location: Carrots
Violation Issued: No

Process/Item: Steam Table
Temperature: 155 Degrees Fahrenheit - Location: Hash browns
Violation Issued: No

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

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS

OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008221036 of 07/26/22.

Certified Food Protection Manager: Jodi L Stotesbury

Certification Number: FM72299 Expires: 03/25/23

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1008
Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008221036

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	0	**Date**	07/26/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:30:21
Legal Authority MN Rules Chapter 4626		**Time Out**	

Waters Edge Assisted Living	**Address** 322 County Highway 6	**City/State** Clinton, MN	**Zip Code** 56225	**Telephone** 3203255414
License/Permit # 0039372	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status				COS	R
Surpervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status				COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A (N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A (N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A (N/O)	Proper cooling time & temperature		
21	(IN)	OUT	N/A N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	(IN)	OUT	N/A N/O	Proper date marking & disposition		
24	IN	OUT	(N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	(IN)	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	(IN)	OUT	N/A	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	(IN) OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) emailed to HRD **Date:** 07/27/22

Inspector (Signature) Inspector ID# 1008