



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2025

Licensee
Water's Edge
800 Agency Trail
Mankato, MN 56001

RE: Project Number(s) SL30108016

Dear Licensee:

On September 15, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 13, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 13, 2025, found not corrected at the time of the September 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

- 0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a) - \$500.00**
- 1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f) - \$500.00**
- 1700 - Provision Of Medication Management Services - 144g.71 Subd. 2 - \$500.00**
- 1730 - Individualized Medication Management Plan - 144g.71 Subd. 5 - \$500.00**

The details of the violations noted at the time of this follow-up survey completed on September 15, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not

required to be submitted for approval.

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 may be 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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/15/2025
NAME OF PROVIDER OR SUPPLIER WATER'S EDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001			
(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 *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30108016-2 On September 9, 2025, through September 15, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a follow-up survey completed on June 3, 2025, and March 13, 2025. At the time of the survey, there were 27 residents; 26 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	{0 480}			

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STATE FORM 6899 UT8D13 If continuation sheet 3 of 22

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{0 775}	Continued From page 3 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 10, 2025, at 4:15 p.m. the surveyor called director of maintenance (DM)-F to follow up on a survey conducted on June 2, 2025. DM-F stated they had installed door closers on approximately half of the first-floor resident rooms and had ordered more door closers that would be installed once they arrive. DM-F emailed surveyor photos of the new door closers that had been installed. DM-F stated they would install door closers on all resident room doors. OBSERVATIONS DURING INTIAL SURVEY ON MARCH 12, 2025 Resident rooms throughout the facility had twenty-minute fire rated doors that did not have self-closing devices. The doors and the door frames had holes that indicated door closers had been installed and were removed. DM-F stated the resident room doors were not equipped with closers since they have been employed at the facility but agreed that closers appeared to have been removed from the doors. State Fire Code in Minnesota Rules, chapter 7511 requires fire-resistant rated doors must be maintained to automatically close and latch as designed to prevent the spread of smoke and fire to adjoining building areas.	{0 775}			

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{0 810}	Continued From page 4	{0 810}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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	{0 810}			

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{0 810}	Continued From page 5 by:	{0 810}	Not reviewed during this survey.		
{01650} SS=E	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; (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 two of three residents'	{01650}			

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{01650}	Continued From page 6 (R1, R4) service plans included all the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's unsigned, service plan/care plan last reviewed August 5, 2025, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	{01650}			

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{01650}	Continued From page 7 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 R4's unsigned, service plan/care plan last reviewed September 4, 2025, indicated R4 required services including medication administration, blood glucose checks, bathing, toileting, oral care, grooming, dressing, mobility/ambulation/escorts/transfers, housekeeping, and laundry. R4's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned	{01650}			

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{01650}	Continued From page 8 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. During the revisit survey on September 9, 2025, at 1:33 p.m., licensed assisted living director (LALD)-C reviewed R1 and R4's service plan/care plan and stated it had not been revised to include all required content since the last survey. LALD-C further stated a service plan with the required content had been developed, but not all residents' service plans had been updated. The licensee's Contents of Service Plans policy, undated, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wished to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on	{01650}			

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{01650}	Continued From page 9 who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned No further information was provided.	{01650}			
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced	{01700}			

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{01700}	Continued From page 10 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R1, R2, R10) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference of the initial survey on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 R1 was admitted on June 6, 2024, and received services under the licensee's Assisted Living with Dementia Care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium	{01700}			

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{01700}	Continued From page 11 deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI (urinary tract infections), and glaucoma. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated October 11, 2024, (127 days after start of services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. During the revisit survey on June 2, 2025, at 2:45 p.m., licensed assisted living director (LALD)-C provided the surveyor with R1's current "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated October 11, 2024. The assessment had not been updated since the last survey to include the required content.	{01700}			

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{01700}	Continued From page 12 During the revisit survey on September 9, 2025, at 11:34 a.m. LALD-C provided the surveyor with R1's "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated August 29, 2025. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R2 R2 was admitted on July 1, 2022, with diagnoses including dementia, type II diabetes, congestive heart failure, insomnia, constipation, gout, and vitamin D deficiency. R2's service plan dated July 7, 2023, identified R2's services included medication administration. R2's prescriber orders dated February 12, 2025, included one medication for diabetes, one for gout, one antipsychotic, two for the heart, one for sleep, one for anemia, one vitamin supplement, and one for constipation. R2's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated June 13, 2024. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. During the revisit survey on June 2, 2025, at 2:45 p.m. LALD-C provided the surveyor with R2's	{01700}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/15/2025
NAME OF PROVIDER OR SUPPLIER WATER'S EDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001			
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{01700}	Continued From page 13 current "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. During the revisit survey on September 9, 2025, at 11:34 a.m. LALD-C provided the surveyor with R1's "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated May 1, 2025. The assessment had not been updated since the last revisit survey to include the required content. R10 R10 was admitted on May 21, 2025, with diagnoses including progressive aphasia (a rare nervous system condition that affects a person's ability to communicate). R10's medication administration record (MAR) dated June 2025, included antifungal powder, one antidepressant, one medication for high blood pressure, and one pain reliever. R10's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated May 21, 2025. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. During the revisit survey on September 9, 2025, at 11:34 a.m., LALD-C provided the surveyor with R10's "Brown Bag" Medication Review Form and	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 14 Face to Face Assessment of Need for Medication Management Services dated May 21, 2025. The assessment had not been updated since the last revisit survey to include the required content. On September 9, 2025, at 1:08 p.m., clinical nurse supervisor (CNS)-O stated being new to the position and was unaware of the requirement to include interventions to prevent diversion with the resident medication assessment. CNS-O reviewed R1, R2, and R10's "Brown Bag" medication assessments and stated they did not include all required content. The licensee's undated, Medication Assessment policy indicated: 1. A medication management assessment will be completed by a registered nurse during the pre-admission assessment, quarterly, with significant change, when a resident requests to start medication management services, or as needed. 2. The RN medication management assessment will be completed face-to-face. 3. The assessment will include: a. Identification of all known medications, supplements, and herbal remedies he resident is currently taking. b. Review medication side effects, contraindications, allergic or adverse reactions. c. Interventions designed to address any side effects, contraindications, allergies, or adverse reactions. d. Interventions to prevent medications diversion. e. Provide instructions to the resident and any legal or designated representative on interventions to prevent diversion of medications.	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 15 No further information was provided.	{01700}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	{01730}			

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{01730}	Continued From page 16 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R10, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference of the initial survey on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 R1 was admitted on June 6, 2024, and received	{01730}			

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{01730}	Continued From page 17 services under the licensee's Assisted Living with Dementia Care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI's (urinary tract infections), and glaucoma. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration. The plan indicted medications will be administered by licensed or certified team members per MD (medical doctor) order. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's record lacked an individual medication management plan that included: - a description of storage of medications based on the resident's needs and preferences, risk of	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 18 diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. On March 11, 2025, at 9:26 a.m., CNS-B stated the current service plan/care plan utilized for most residents also included the medication management and treatment plan, which did not include the above required content. CNS-B further stated the previous individualized medication management and treatment plans the licensee utilized contained the required content, and only residents who had been at the facility long-standing with no changes to their services would have the correct medication management plan in place. During the revisit survey on June 2, 2025, at 2:55 p.m., licensed assisted living director (LALD)-C stated he was unable to locate a revised individualized medication management plan for R1 with the required content. R10 R10 was admitted on May 21, 2025, with diagnoses including progressive aphasia (a rare nervous system condition that affects a person's ability to communicate). R10's unsigned, service plan/care plan initiated	{01730}			

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{01730}	Continued From page 19 May 21, 2025, indicated R10 required services including medication administration, bathing, oral care, grooming, dressing, housekeeping, and laundry. R10's medication administration record (MAR) dated June 2025, included one antifungal powder, one antidepressant, one medication for high blood pressure, and one pain reliever. R10's Client Individualized Medication Management Plan dated May 21, 2025, lacked: - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. R11 R11 was admitted on May 6, 2025, with diagnoses including Alzheimer's disease. R11's service plan/care plan dated May 6, 2025, indicated R11 required services including medication administration, bathing, toileting/pericare, housekeeping and laundry. R11's medication administration record (MAR) dated June 2025, included one antidepressant medication. R11's undated, Client Individualized Medication Management Plan lacked: - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. During the revisit survey on June 3, 2025, at 9:34 p.m., CNS-L stated being unaware an	{01730}			

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{01730}	Continued From page 20 individualized medication management plan needed to be completed. CNS-L reviewed R10 and R11's medication management plans and stated the form utilized for all residents did not include procedures to notify a registered nurse when problems arise. During the revisit survey on September 9, 2025, at 1:18 p.m. LALD-C provided the surveyor with the new form they will be utilizing moving forward for all resident's individualized medication management plans; the form included all required content. LALD-C further stated the new form had not been implemented yet for any of the licensee's residents. The licensee's undated, Individualized Medication, Treatment & Therapy Management Plans policy indicated: 5. Medication Management Plans: RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications e. Identification of medication management tasks that may be delegated to an unlicensed person	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 21 f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications with all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions. No further information was provided.	{01730}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 6, 2025

Licensee
Water's Edge
800 Agency Trail
Mankato, MN 56001

RE: Project Number(s) SL30108016

Dear Licensee:

On June 3, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on March 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 13, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on March 13, 2025, found not corrected at the time of the June 3, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b) - \$500.00
0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 - \$500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - \$500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 - \$500.00
1730-Individualized Medication Management Plan-144g.71 Subd. 5 - \$500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on June 3, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on June 3, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00
1890-Prescription Drugs-144g.71 Subd. 20

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

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 may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized, flowing script.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2025
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30108016-1 On June 2, 2025, through June 3, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on xx. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued/ issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on June 3, 2025. 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	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 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 revisit survey on June 3, 2025, a review of the licensee's policies and procedures, resident records, and employee records, lacked evidence to indicate the licensee had attempted to correct all the orders issued for the survey concluded on March 13, 2025. Reissued orders include: 0630, 1440, 1650, 1700, 1730, and 1940. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	{0 480}			

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{0 480}	Continued From page 3 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
			Not reviewed during this survey.		

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{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on June 6, 2024, with diagnoses including mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and type II	{0 630}			

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{0 630}	Continued From page 5 diabetes mellitus. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's progress note dated January 31, 2025, at 13:51 (1:51 p.m.) by licensed assisted living director (LALD)-C indicated writer was informed during standup that resident had packed up apartment and planned to be picked up and move out. Resident has history of financial exploitation and being scammed into purchasing gift cards. R1's IAPP dated June 6, 2024, failed to identify if R1 was at risk for abuse and interventions to prevent abuse. R2 R2 was admitted on July 1, 2022, with diagnoses including dementia, type II diabetes, and congestive heart failure. R2's service plan dated July 7, 2023, identified R2's services included dressing, grooming, bathing, toileting, medication administration, blood glucose monitoring, behavior monitoring, housekeeping, and laundry. R2's progress note dated January 28, 2025, at 18:14 (6:14 p.m.) indicated: Writer was contacted by a staff member stating that while staff were attempting to assist resident after he had a BM (bowel movement), resident became physically aggressive toward staff. Resident hit staff member repeatedly in the thigh and one in the head hard enough where staff member "saw	{0 630}			

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{0 630}	Continued From page 6 stars." Staff were able to finish caring for resident and were able to get him settled into bed. R2's IAPP dated June 13, 2024, failed to identify if R2 was at risk for abuse, was at risk to abuse others, and interventions to prevent abuse. On March 11, 2025, at 2:13 p.m., clinical nurse supervisor (CNS)-B stated the IAPP should include risk for abuse and interventions to prevent abuse. CNS-B further stated being aware the IAPP utilized for all residents in the facility was lacking required content as this was recently identified during a survey at one of their other facilities that utilized the same form. During the revisit survey on June 3, 2025, at 9:34 a.m. licensed assisted living director (LALD)-A and CNS-L reviewed R1 and R2's IAPP's which had not been reassessed since the last survey. LALD-A stated not realizing the IAPP hadn't been updated. CNS-L stated she had not started employment until after the original survey and did not realize R1 and R2's IAPP's needed to be updated. The licensee's undated, Vulnerable Adult Maltreatment Policy indicated: 1. An abuse prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services 2. The individual abuse prevention plan will: a. Be based upon an individualized review or assessment of the resident's i. susceptibility to abuse by another individual, including other vulnerable adults ii. risk of abusing other vulnerable adults b. specific measures to be taken to minimize the risk of abuse to others and self-abuse.	{0 630}			

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{0 630}	Continued From page 7 No further information was provided.	{0 630}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 2, 2025, the surveyor initiated a follow-up for a survey conducted on March 12, 2025. Surveyor entered the facility at 1:03 p.m. and was met by licensed assisted living director (LALD)-C. LALD-C stated the director of maintenance (DM)-F was on the way to the facility. During facility tour on June 2, 2025, from 1:33 p.m. through 1:59 p.m., with (LALD)-C and (DM)-F, the surveyor observed resident room doors that did not have self-closing devices	{0 775}			

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{0 775}	Continued From page 8 installed. DM-F stated the resident room doors were the same as during the last survey. DM-F stated that they had contractors submit quotes for installing door closers, but the corporate office needs to approve the quotes prior to the work being completed. OBSERVATIONS DURING INTIAL SURVEY ON MARCH 12, 2025 Resident rooms throughout the facility had twenty-minute fire rated doors that did not have self-closing devices. The doors and the door frames had holes that indicated door closers had been installed and were removed. DM-F stated the resident room doors were not equipped with closers since they have been employed at the facility but agreed that closers appeared to have been removed from the doors. State Fire Code in Minnesota Rules, chapter 7511 requires fire-resistant rated doors must be maintained to automatically close and latch as designed to prevent the spread of smoke and fire to adjoining building areas.	{0 775}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}			

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{0 810}	Continued From page 9 (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) Staff 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 staff 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:	{0 810}	Not reviewed during this survey.		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems	{01440}			

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{01440}	Continued From page 10 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of three of three newly hired unlicensed personnel (ULP-D, ULP-H, ULP-I) performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D	{01440}			

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{01440}	Continued From page 11 ULP-D was hired December 16, 2024, to provide direct care services. On March 11, 2025, at 8:45 a.m., the surveyor observed ULP-D administering medications to R1. ULP-D's employee record did not include a 30-day direct supervisory review. On March 13, 2024, at 12:17 p.m., licensed assisted living director (LALD)-C stated he was unable to find evidence a 30-day supervisory review had been completed by the registered nurse. ULP-H ULP-H was hired on March 25, 2025, to provide direct care services. ULP-H's employee record did not include a 30-day direct supervisory review. ULP-I ULP-I was hired on March 25, 2025, to provide direct care services. ULP-I's employee record did not include a 30-day direct supervisory review. During the revisit survey on June 3, 2025, at 9:34 a.m., LALD-C and clinical nurse supervisor (CNS)-L stated 30-day supervision of staff had not been completed for ULP-D or any new employees since the last survey. No further information as provided.	{01440}			

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{01650}	Continued From page 12	{01650}			
{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; (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 three of three resident's (R1, R4, R10) service plans included all the required content. This practice resulted in a level two violation (a	{01650}			

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{01650}	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and	{01650}			

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{01650}	Continued From page 14 declarations made by the resident under those chapters. On March 11, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-B stated the resident care plan was also considered the service plan and was signed by the resident or their representative. CNS-B stated the current service plan/care plan utilized for all residents did not include the above required content. CNS-B further stated the previous service plan the licensee utilized contained the required content and only residents who had been at the facility long-standing with no changes to their services would have that service plan with the required content. R4 R4's unsigned, service plan/care plan last reviewed May 12, 2025, indicated R4 required services including medication administration, blood glucose checks, bathing, toileting, oral care, grooming, dressing, mobility/ambulation/escorts/transfers, wound care, housekeeping, and laundry. R4's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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	{01650}			

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{01650}	Continued From page 15 identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R10 R10's unsigned, service plan/care plan initiated May 21, 2025, indicated R10 required services including medication administration, bathing, oral care, grooming, dressing, housekeeping, and laundry. R10's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}			

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{01650}	Continued From page 16 During the revisit survey on June 3, 2025, at 9:34 a.m., LALD-C reviewed R1's service plan/care plan and stated it had not been revised since the last survey. LALD-C further stated R4 an R10's service plan/care plans did not include the required content identified in the last survey. The care plans also had not been signed by the resident/representative or the registered nurse (RN). LALD-C stated not realizing the current service plan/care plan being utilized by all residents did not include all required content. The licensee's Contents of Service Plans policy, undated, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wished to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency	{01650}			

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NAME OF PROVIDER OR SUPPLIER WATER'S EDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001			
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{01650}	Continued From page 17 vi. Circumstances in which emergency medical services are not to be summoned No further information was provided.	{01650}			
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01700}			

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{01700}	Continued From page 18 review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R1, R2, R10) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 R1 was admitted on June 6, 2024, and received services under the licensee's Assisted Living with Dementia Care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI (urinary tract infections), and glaucoma.	{01700}			

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{01700}	Continued From page 19 R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated October 11, 2024, (127 days after start of services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. During the revisit survey on June 2, 2025, at 2:45 p.m., licensed assisted living director (LALD)-C provided the surveyor with R1's current "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated October 11, 2024. The assessment had not been updated since the last survey to include the required content. R2 R2 was admitted on July 1, 2022, with diagnoses including dementia, type II diabetes, congestive heart failure, insomnia, constipation, gout, and	{01700}			

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{01700}	Continued From page 20 vitamin D deficiency. R2's service plan dated July 7, 2023, identified R2's services included medication administration. R2's prescriber orders dated February 12, 2025, included one medication for diabetes, one for gout, one antipsychotic, two for the heart, one for sleep, one for anemia, one vitamin supplement, and one for constipation. R2's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated May 1, 2025. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R10 R10 was admitted on May 21, 2025, with diagnoses including progressive aphasia (a rare nervous system condition that affects a person's ability to communicate). R10's medication administration record (MAR) dated June 2025, included antifungal powder, one antidepressant, one medication for high blood pressure, and one pain reliever. R10's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated May 21, 2025. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications.	{01700}			

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{01700}	Continued From page 21 On June 3, 2025, at 9:34 a.m., LALD-A and clinical nurse supervisor (CNS)-C reviewed R1, R2, and R10's medication assessments and stated they did not include the required content related to interventions to prevent diversion. The licensee's undated, Medication Assessment policy indicated: 1. A medication management assessment will be completed by a registered nurse during the pre-admission assessment, quarterly, with significant change, when a resident requests to start medication management services, or as needed. 2. The RN medication management assessment will be completed face-to-face. 3. The assessment will include: a. Identification of all known medications, supplements, and herbal remedies he resident is currently taking. b. Review medication side effects, contraindications, allergic or adverse reactions. c. Interventions designed to address any side effects, contraindications, allergies, or adverse reactions. d. Interventions to prevent medications diversion. e. Provide instructions to the resident and any legal or designated representative on interventions to prevent diversion of medications. No further information was provided.	{01700}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified	{01730}			

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{01730}	Continued From page 22 staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	{01730}			

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{01730}	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R10, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 R1 was admitted on June 6, 2024, and received services under the licensee's Assisted Living with Dementia Care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium	{01730}			

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{01730}	Continued From page 24 deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI's (urinary tract infections), and glaucoma. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration. The plan indicted medications will be administered by licensed or certified team members per MD (medical doctor) order. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's record lacked an individual medication management plan that included: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services.	{01730}			

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{01730}	Continued From page 25 On March 11, 2025, at 9:26 a.m., CNS-B stated the current service plan/care plan utilized for most residents also included the medication management and treatment plan, which did not include the above required content. CNS-B further stated the previous individualized medication management and treatment plans the licensee utilized contained the required content, and only residents who had been at the facility long-standing with no changes to their services would have the correct medication management plan in place. During the revisit survey on June 2, 2025, at 2:55 p.m., licensed assisted living director (LALD)-C stated he was unable to locate a revised individualized medication management plan for R1 with the required content. R10 R10 was admitted on May 21, 2025, with diagnoses including progressive aphasia (a rare nervous system condition that affects a person's ability to communicate). R10's unsigned, service plan/care plan initiated May 21, 2025, indicated R10 required services including medication administration, bathing, oral care, grooming, dressing, housekeeping, and laundry. R10's medication administration record (MAR) dated June 2025, included one antifungal powder, one antidepressant, one medication for high blood pressure, and one pain reliever. R10's Client Individualized Medication Management Plan dated May 21, 2025, lacked: - procedures for staff notifying a RN or	{01730}			

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{01730}	Continued From page 26 appropriate licensed health professional when a problem arises with medication management services. R11 R11 was admitted on May 6, 2025, with diagnoses including Alzheimer's disease. R11's service plan/care plan dated May 6, 2025, indicated R11 required services including medication administration, bathing, toileting/pericare, housekeeping and laundry. R11's medication administration record (MAR) dated June 2025, included one antidepressant medication. R11's undated, Client Individualized Medication Management Plan lacked: - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. During the revisit survey on June 3, 2025, at 9:34 p.m., CNS-L stated being unaware an individualized medication management plan needed to be completed. CNS-L reviewed R10 and R11's medication management plans and stated the form utilized for all residents did not include procedures to notify a registered nurse when problems arise. The licensee's undated, Individualized Medication, Treatment & Therapy Management Plans policy indicated: 5. Medication Management Plans: RN will develop a medication management plan for each resident receiving medication management	{01730}			

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{01730}	Continued From page 27 services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications e. Identification of medication management tasks that may be delegated to an unlicensed person f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications with all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions. No further information was provided.	{01730}			
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.	01890			

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01890	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R13) with insulin. 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: R13 had diagnoses including type II diabetes mellitus. R13's physician orders dated May 14, 2025, included: Novolog FlexPen 100 unit/ml (milliliter) subcutaneous solution pen-injector, inject 7 units PLUS sliding scale before lunch and supper. On June 3, 2025, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-M set up R13's Novolog insulin for administration; the insulin pen was not dated when opened. ULP-M stated all insulin pens are to be dated when opened and that is how they were trained. On June 3, 2025, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-L stated insulin pens should be dated when opened. The Novolog FlexPen Instructions For Use	01890			

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01890	Continued From page 29 revised April 2015, indicated the Novolog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
{01940} SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	{01940}			

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{01940}	Continued From page 30 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 three residents (R1). 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 March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents including assistance with oxygen, CPAP (continuous positive airway pressure) machine. R1's provider orders dated February 12, 2025, included: oxygen with CPAP at 1 liter for sleep. On March 13, 2025, at 11:42 a.m., the surveyor observed R1 seated in her recliner chair in her room; a CPAP machine and oxygen concentrator were within reach of the recliner. R1's service plan/care plan last reviewed April 29,	{01940}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2025
NAME OF PROVIDER OR SUPPLIER WATER'S EDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001		
(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 31 2025, indicated R1 received services including assistance with CPAP machine and oxygen. The plan further directed staff to make sure resident hooks oxygen correctly to CPAP. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On March 13, 2025, at 11:25 a.m., CNS-B reviewed R1's treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with the resident's oxygen or CPAP machine. During the revisit survey on June 3, 2025, at 9:34 a.m., CNS-L reviewed R1's Service plan/care plan and stated it did not include specifics when to contact a nurse related to the CPAP machine and oxygen use. The licensees undated, Individualized Medication, Treatment & Therapy Management Plans policy indicated: 6. Treatment and Therapy Management Plans: RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment and/or therapy services. No further information was provided.	{01940}			

Minnesota Department of Health

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{02040}	Continued From page 32	{02040}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}			
			Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 11, 2025

Licensee
Water's Edge
800 Agency Trail
Mankato, MN 56001

RE: Project Number(s) SL30108016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH 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 may be 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.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER WATER'S EDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001		
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0 000	Initial Comments 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: SL30108016-0 On March 10, 2025, through March 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 29 residents; 29 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was identified on March 11, 2025, at a level 3/Widespread (I). The licensee took action on March 11, 2025; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all 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 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 had a assisted living with dementia care license effective October 1, 2024. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the authorized agent on June 14, 2024. As a result of this survey, the following orders were issued under 0480, 0630, 0680, 0730, 0775, 0810, 1290, 1370, 1380, 1440, 1500, 1610, 1620, 1650, 1700, 1730, 1750, 1790, 1940, 1960, 2040, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one	0 420			

Minnesota Department of Health

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0 420	Continued From page 3 (21) days	0 420			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 12, 2025, for the specific	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2025
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0 480	Continued From page 5 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). 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	0 630			

Minnesota Department of Health

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0 630	Continued From page 6 a large portion or all of the residents). The findings include: R1 R1 was admitted on June 6, 2024, with diagnoses including mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and type II diabetes mellitus. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's progress note dated January 31, 2025, at 13:51 (1:51 p.m.) by licensed assisted living director (LALD)-C indicated writer was informed during standup that resident had packed up apartment and planned to be picked up and move out. Resident has history of financial exploitation and being scammed into purchasing gift cards. R1's IAPP dated June 6, 2024, failed to identify if R1 was at risk for abuse and interventions to prevent abuse. R2 R2 was admitted on July 1, 2022, with diagnoses including dementia, type II diabetes, and congestive heart failure. R2's service plan dated July 7, 2023, identified R2's services included dressing, grooming, bathing, toileting, medication administration, blood glucose monitoring, behavior monitoring, housekeeping, and laundry.	0 630			

Minnesota Department of Health

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0 630	Continued From page 7 R2's progress note dated January 28, 2025, at 18:14 (6:14 p.m.) indicated: Writer was contacted by a staff member stating that while staff were attempting to assist resident after he had a BM (bowel movement), resident became physically aggressive toward staff. Resident hit staff member repeatedly in the thigh and one in the head hard enough where staff member "saw stars." Staff were able to finish caring for resident and were able to get him settled into bed. R2's IAPP dated June 13, 2024, failed to identify if R2 was at risk for abuse, was at risk to abuse others, and interventions to prevent abuse. On March 11, 2025, at 2:13 p.m., clinical nurse supervisor (CNS)-B stated the IAPP should include risk for abuse and interventions to prevent abuse. CNS-B further stated being aware the IAPP utilized for all residents in the facility was lacking required content as this was recently identified during a survey at one of their other facilities that utilized the same form. The licensee's undated, Vulnerable Adult Maltreatment Policy indicated: 1. An abuse prevention plan will be completed for each resident in the assisted living by day 14 after move-in or receipt of services 2. The individual abuse prevention plan will: a. Be based upon an individualized review or assessment of the resident's i. susceptibility to abuse by another individual, including other vulnerable adults ii. risk of abusing other vulnerable adults b. specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information was provided.	0 630			

Minnesota Department of Health

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0 630	Continued From page 8	0 630			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Seven (7) days 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 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 an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required	0 680			

Minnesota Department of Health

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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
0 680	Continued From page 9 elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The EPP indicated it was last reviewed and updated on November 7, 2023. The Emergency Preparedness Plan lacked the following required content: - be updated annually with documentation of date of review and updates made to the plan based on the review; - an all-hazards risk assessment categorizing the various probable risk/hazards by likelihood of occurrence; - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy.	0 680			

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0 680	Continued From page 10 On March 13, 2025, at 3:36 p.m., the surveyor sent an email to licensed assistant living director (LALD)-C requesting the above documentation. At approximately 3:59 p.m., LALD-C stated he would attempt to locate the above documentation and send to the surveyor via email. 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	0 730			

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0 730	Continued From page 11 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the 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 the required content for one of one discharged resident (R3). 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 12 R3's start of care for services was August 30, 2024, and was discharged on December 2, 2024. R3's service plan/care plan dated September 9, 2024, indicted services included assistance with bathing, toileting/incontinence care, oral care, transfer/escorts/mobility, medication administration, oxygen therapy, housekeeping, and laundry. 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. On March 13, 2025, at 8:48 a.m., clinical nurse supervisor (CNS)-B stated being unable to locate evidence a discharge summary with the required content was completed for R3. The licensee's undated, form titled: Contents of Resident Record indicated: Include the following for each resident in their record: - a discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTIONS:	0 730			

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0 730	Continued From page 13 Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on March 12, 2025, from 10:06 a.m. through 11:22 a.m., with licensed assisted living director (LALD)-C and director of maintenance (DM)-F, the surveyor observed the following: FIRE RESISTANT RATED DOORS Resident rooms throughout the facility had twenty-minute fire rated doors that did not have self-closing devices. The doors and the door frames had holes that indicated door closers had	0 775			

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0 775	Continued From page 14 been installed and were removed. DM-F stated the resident room doors were not equipped with closers since they have been employed at the facility but agreed that closers appeared to have been removed from the doors. One hour rated doors at the first, second, and third-floor elevator lobby were held open with a wedge. State Fire Code in Minnesota Rules, chapter 7511 requires fire-resistant rated doors must be maintained to automatically close and latch as designed to prevent the spread of smoke and fire to adjoining building areas. LOCKED EXITS The surveyor observed doors on the third floor to each stairwell and on the second floor to the stairwell by resident room 212 that were equipped with magnetic locks that required a code to unlock. DM-F stated the doors would unlock when the fire alarm was activated and that they were also delayed egress. DM-F pushed the doors to open and within fifteen seconds the doors released. The doors did not have a sign on them as required by State Fire Code in Minnesota Rules, chapter 7511, that indicates the delayed egress function. The surveyor observed a door with an illuminated exit sign above leading into the second-floor stairwell by the elevator. The door had a lock that required a code to unlock. State Fire Code in Minnesota Rules, chapter 7511, requires egress doors be openable from the egress side without the use of a key or special knowledge. LALD-C and DM-F verified the above findings	0 775			

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0 775	Continued From page 15 while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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.	0 810			

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0 810	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 12, 2025, at 11:25 a.m., licensed assisted living director (LALD)-C and director of maintenance (DM)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensees FSEP untitled, undated, lacked the following required content: The FSEP did not identify employee procedures and actions to take in the event of a fire or similar emergency. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but lacked procedures for how staff are to complete each step.	0 810			

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0 810	Continued From page 17 The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. DM-F stated they do training during drills and provide annual training provided by a third party but do not provide in-person training specific to the facility FSEP. During an interview on March 12, 2025, at 12:04 p.m., LALD-C and DM-F stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith	01290			

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01290	Continued From page 18 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for two of three employees (unlicensed personnel (ULP)-E, culinary director (CD)-G). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on March 11, 2025. 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). The findings include: ULP-E ULP-E was hired on February 3, 2021, to provide direct care services for the licensee's residents under the previous home care licensure. On March 11, 2025, at 8:17 a.m., the surveyor observed ULP-E administering medications to	01290			

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01290	Continued From page 19 R2. On March 11, 2025, at 2:25 p.m., licensed assisted living director (LALD)-C provided the surveyor with ULP-D's employee file. LALD-C stated ULP-D was not included on the NETStudy roster but he had a background study in the employee's file. The background study was under the HFID (health facility identification) number 30109 (the facility's previous HFID), and not the current HFID 30108. LALD-C stated ULP-D was a long-term employee and had been working independently at the facility since 2021. NETStudy 2.0 employee roster for HFID 30109 indicated ULP-D had been affiliated on February 2, 2021, and separated from employment on Mary 31, 2021. CD-G CD-G was hired March 12, 2021, as the shared culinary director for the licensee and their sister facility. On March 11, 2025, at 11:48 a.m., the surveyor observed CD-G on the first floor in the open kitchenette overseeing the lunch meal service and interacting with residents. On March 11, 2024, at 2:25 p.m., LALD-C stated he was unable to gain access to ULP-D's information in NETStudy 2.0 related to HFID 30109. LALD-C stated to his knowledge ULP-D had never separated from employment; LALD-C called ULP-D who stated she had never left employment other than to take FMLA (Family Medical Leave Act). LALD-C stated CD-G worked independently for the licensee and also for another sister facility in town. CD-G's background study dated August 27, 2021, was	01290			

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01290	Continued From page 20 affiliated to HFID 30108, but indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 roster page 5. LALD-C was not aware CD-G's background study was COVID-19 NETStudy 2.0 expired and stated all employees were required to have a cleared background check before performing duties at the facility. The Minnesota Department of Human Services website updated July 31, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid and modifications ended January 1, 2023. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's undated, Background Check policy indicated: When a background or reference check is needed with respect to hiring or other employment decisions, the company conducts	01290			

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01290	Continued From page 21 such checks in compliance with applicable federal, state and local laws. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 11, 2025, the licensee took action to mitigate the identified risk; however, the scope and level remains at I.	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370			

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01370	Continued From page 22 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-D) completed training and competency evaluations as required prior to providing direct care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired December 16, 2024, to provide direct care services. On March 11, 2025, at 8:45 a.m., the surveyor observed ULP-D administering medications to	01370			

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01370	Continued From page 23 R1. ULP-D's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting On March 13, 2025, at 2:47 p.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-C stated ULP-D had been working independently providing direct care. CNS-B and LALD-C further stated being unable to locate evidence the above required trainings/competencies had been completed. The licensee's undated, Delegation of Nursing Tasks policy indicated: 1. A registered nurse (RN) may delegate nursing services, or an authorized licensed health professional may delegate treatments or assign therapy task, to unlicensed personnel that: a. have successfully completed the training required for unlicensed personnel, b. have been trained in the services to be provided, c. have demonstrated to the RN or the licensed health professional the ability to competently follow the procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370			

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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
01370	Continued From page 24 (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-D). completed training and competency evaluations prior to providing direct care as required. 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	01380			

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01380	Continued From page 25 situation has occurred only occasionally). The findings include: ULP-D was hired December 16, 2024, to provide direct care services. On March 11, 2025, at 8:45 a.m., the surveyor observed ULP-D administering medications to R1. ULP-D's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motioning and positioning. On March 13, 2025, at 2:47 p.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-C stated ULP-D had been working independently providing direct care. CNS-B and LALD-C further stated being unable to locate evidence the above required trainings/competencies had been completed. The licensee's undated, Delegation of Nursing Tasks policy indicated: 1. A registered nurse (RN) may delegate nursing services, or an authorized licensed health professional may delegate treatments or assign therapy task, to unlicensed personnel that: a. have successfully completed the training required for unlicensed personnel, b. have been trained in the services to be provided, c. have demonstrated to the RN or the licensed health professional the ability to competently follow the procedures for the	01380			

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01380	Continued From page 26 resident and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct	01440			

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01440	Continued From page 27 supervision of one of one newly hired unlicensed personnel (ULP-D) performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired December 16, 2024, to provide direct care services. On March 11, 2025, at 8:45 a.m., the surveyor observed ULP-D administering medications to R1. ULP-D's employee record did not include a 30-day direct supervisory review. On March 13, 2024, at 12:17 p.m., licensed assisted living director (LALD)-C stated he was unable to find evidence a 30-day supervisory review had been completed by the registered nurse. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			

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01500	Continued From page 28	01500			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 29 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired February 3, 2021, to provide	01500			

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01500	Continued From page 30 direct care services. On March 11, 2025, at 8:17 a.m., the surveyor observed ULP-E administering medications to R2. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery On March 13, 2025, at 2:47 p.m., licensed assisted living director (LALD)-C reviewed ULP-E's employee record and stated it did not contain the above required annual training. The licensee's undated, Annual Training policy indicated: 1. All assisted living employees will complete annual education on the following topics: g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery i. How person-centered planning and delivery applies to direct support services provided by staff No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610			

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01610	Continued From page 31 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) prior to initiation of services. 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 mild cognitive	01610			

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01610	Continued From page 32 impairment, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and type II diabetes mellitus. R1's start of care date for services was June 6, 2024. R1's assisted living contract was signed by R1 on June 6, 2024. R1's medication administration record (MAR) dated June 2024, indicated the resident was administered medication by the licensee's staff the evening of June 6, 2024. R1's admission assessment completed by the RN was dated June 7, 2024. The assessment was not completed prior to the initiation of services on June 6, 2024. On March 11, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-B reviewed R1's admission assessment and stated it had not been signed off by the RN prior to the start of services as required. The licensee's Initial and On-Going Nursing Assessment of Residents policy, undated, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in condition	01610			

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01610	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01620 SS=E	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 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 not to exceed 90 calendar days from the last	01620			

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01620	Continued From page 34 assessment, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's last three assessments were requested. Assessments dated September 3, 2024, December 5, 2024, and March 10, 2025, were provided. 93 days had passed between the September and December 2024, assessments (three days late), and 95 days had passed between the December 2024 and March 2025, assessments (five days late). R2 R2's service plan dated July 7, 2023, identified R2's services included dressing, grooming, bathing, toileting, medication administration, blood glucose monitoring, behavior monitoring, housekeeping, and laundry. R2's last three assessments were requested.	01620			

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01620	Continued From page 35 Assessments dated September 5, 2024, December 5, 2024, and March 10, 2025, were provided. 91 days had passed between the September and December 2024, assessments (one day late), and 95 days had passed between the December 2024 and March 2025, assessments (five days late). On March 11, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's record and stated the last two comprehensive assessments had been completed late. The licensee's Initial and On-Going Nursing Assessment of Residents policy, undated, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in condition 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	01650			

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01650	Continued From page 36 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; (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 one of two resident's (R1) service plans included all the required content. 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	01650			

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01650	Continued From page 37 a large portion or all of the residents). The findings include: R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration, bathing, compression stockings, blood glucose checks, oxygen/CPAP (continuous positive airway pressure machine), housekeeping, and laundry. R1's service plan lacked the following: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On March 11, 2025, at 1:54 p.m., clinical nurse supervisor (CNS)-B stated the resident care plan was also considered the service plan and was signed by the resident or their representative. CNS-B stated the current service plan/care plan	01650			

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NAME OF PROVIDER OR SUPPLIER WATER'S EDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 AGENCY TRAIL MANKATO, MN 56001		
(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
01650	Continued From page 38 utilized for all residents did not include the above required content. CNS-B further stated the previous service plan the licensee utilized contained the required content and only residents who had been at the facility long-standing with no changes to their services would have that service plan with the required content. The licensee's Contents of Service Plans policy, undated, indicated: 5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services f. Contingency plan g. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wished to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. Circumstances in which emergency medical services are not to be summoned No further information was provided.	01650			

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01650	Continued From page 39	01650			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face	01700			

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01700	Continued From page 40 medication management assessment to include all required content for two of two residents (R1, R2) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 R1 was admitted on June 6, 2024, and received services under the licensee's assisted living with dementia care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI (urinary tract infections), and glaucoma. R1's service plan/care plan signed June 17, 2024,	01700			

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01700	Continued From page 41 indicated R1 required services including medication administration. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated October 11, 2024, (127 days after start of services). The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R2 R2 was admitted on July 1, 2022, with diagnoses including dementia, type II diabetes, congestive heart failure, insomnia, constipation, gout, and vitamin D deficiency. R2's service plan dated July 7, 2023, identified R2's services included medication administration. R2's prescriber orders dated February 12, 2025, included one medication for diabetes, one for gout, one antipsychotic, two for the heart, one for sleep, one for anemia, one vitamin supplement, and one for constipation.	01700			

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01700	Continued From page 42 R2's record included a "Brown Bag" Medication Review Form and Face to Face Assessment of Need for Medication Management Services dated June 13, 2024. The assessment did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On March 13, 2025, at 1:56 p.m., CNS-B stated the "Brown Bag" medication assessment utilized for all residents did not include interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. CNS-B reviewed R1's record and could not locate evidence a face-to-face assessment of all R1's medications had been completed prior to initiation of services. The licensee's undated, Medication Assessment policy indicated: 1. A medication management assessment will be completed by a registered nurse during the pre-admission assessment, quarterly, with significant change, when a resident requests to start medication management services, or as needed. 2. The RN medication management assessment will be completed face-to-face. 3. The assessment will include: a. Identification of all known medications, supplements, and herbal remedies he resident is currently taking. b. Review medication side effects, contraindications, allergic or adverse reactions. c. Interventions designed to address any side effects, contraindications, allergies, or adverse reactions. d. Interventions to prevent medications	01700			

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01700	Continued From page 43 diversion. e. Provide instructions to the resident and any legal or designated representative on interventions to prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730			

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01730	Continued From page 44 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1 was admitted on June 6, 2024, and received	01730			

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01730	Continued From page 45 services under the licensee's assisted living with dementia care license. R1's diagnoses included mild cognitive impairment, post-traumatic stress disorder, major depressive disorder, diabetes mellitus with chronic kidney disease and diabetic neuropathy, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hyperlipidemia (high cholesterol), gastroesophageal reflux disease (GERD/heartburn), magnesium deficiency syndrome, vitamin D and B12 deficiency, osteopenia (reduced bone density), chronic pain syndrome, history of UTI's (urinary tract infections), and glaucoma. R1's service plan/care plan signed June 17, 2024, indicated R1 required services including medication administration. The plan indicted medications will be administered by licensed or certified team members per MD (medical doctor) order. R1's prescriber orders dated February 12, 2025, included three medications for diabetes, two for depression, three for the heart, two for high cholesterol, one for UTI prevention, two for allergies, two for GERD, one for osteopenia, one for COPD, two vitamin supplements, one magnesium supplement, and one for glaucoma. On March 11, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R1. R1's individual medication management plan lacked: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730			

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01730	Continued From page 46 directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. On March 11, 2025, at 9:26 a.m., CNS-B stated the current service plan/care plan utilized for most residents also included the medication management and treatment plan, which did not include the above required content. CNS-B further stated the previous individualized medication management and treatment plans the licensee utilized contained the required content, and only residents who had been at the facility long-standing with no changes to their services would have the correct medication management plan in place. The licensee's undated Individualized Medication, Treatment & Therapy Management Plans policy indicated: 5. Medication Management Plans: RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident	01730			

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01730	Continued From page 47 instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications e. Identification of medication management tasks that may be delegated to an unlicensed person f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications with all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750			

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01750	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by unlicensed personnel (ULP) for one of one resident (R1) observed receiving insulin. 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 type 2 diabetes. R1's service plan/care plan dated June 17, 2024, indicated services included medication administration. R1's provider visit note dated February 12, 2025, included an order for Novolog Flexpen (insulin aspart) 100 unit/milliliter, inject 10 units three times daily before meals along with SSI (sliding scale insulin) as instructed (hold if glucose less than 70). On March 11, 2025, at 8:45 a.m., the surveyor observed ULP-D setting up and administering R1's scheduled morning medications including the insulin aspart pen. ULP-D first checked R1's blood glucose level via the resident's Freestyle Libre continuous glucose monitor. R1's blood	01750			

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01750	Continued From page 49 glucose value was 102; ULP-D stated R1 would not need any additional insulin per the sliding scale. ULP-D removed the cap from R1's insulin pen and applied a needle. ULP-D then dialed the dose on the pen to 10 units and administered the insulin subcutaneously in R1's left upper arm. ULP-D did not cleanse the port of the insulin pen prior to applying the needle, did not prime the insulin pen prior to dialing up the dose, and did not cleanse R1's skin with alcohol prior to administering the insulin. When interviewed immediately following the observation, ULP-D stated she does not prime insulin pens as when she last worked in Wisconsin was told the new insulin pens do not require priming. Related to cleansing the port of the pen with alcohol prior to applying the needle, stated she had not been trained to do this. ULP-D further stated she does cleanse the resident's skin with alcohol prior to the insulin injection but didn't do this for R1 as the resident refuses because it "stings". On March 11, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated staff are trained to prime insulin pens with two units prior to dialing up the scheduled dose to remove any air from the pen. Staff are also trained to cleanse the resident's skin with alcohol prior to injection. CNS-B stated she does not train staff to cleanse the port of the insulin pen with alcohol prior to attaching the needle. ULP-D's Medication Administration - Subcutaneous Injection competency dated and signed by a registered nurse on February 5, 2025, indicated: Insulin Pens: 1. Review the MAR (medication administration record), if resident needs glucose monitoring, do this before administering insulin. Document	01750			

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01750	Continued From page 50 result of the blood glucose monitoring on the MAR and follow any patient-specific instructions listed on the MAR. 2. Insulin pens are to be stored at room temperature after first use (unless otherwise indicated by manufacturer) 3. Roll the pen gently before use 4. Remove the pen cap and clean with alcohol wipe 5. Connect the needle to the pen 6. Prime the pen per manufacturer instructions (see MAR); to remove any air bubbles that may be present 7. Dial the dose of insulin to be given on the pen. 8. Clean the pre-planned alternating injection site (see MAR) with alcohol wipe or soap and water. If using the abdomen, remain four inches away from the navel (belly button). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01790 SS=D	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	01790			

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01790	Continued From page 51 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 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	01790			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2025
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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
01790	Continued From page 52 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 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of two employees (unlicensed personnel (ULP)-E) providing medications for residents with unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: ULP-E was hired on February 3, 2021, to provide direct care services to residents of the facility. On March 11, 2025, at 8:17 a.m., the surveyor observed ULP-E administering medications to R2. ULP-E's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home.	01790			

Minnesota Department of Health

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01790	Continued From page 53 On March 13, 2025, at 2:47 p.m., licensed assisted living director (LALD)-C stated ULP-E's employee record did not include evidence of the above training or competency. The licensee's undated, Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy indicated: Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven days of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790			
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940			

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01940	Continued From page 54 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 two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 10, 2025, at 11:37 a.m., clinical nurse supervisor	01940			

Minnesota Department of Health

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01940	Continued From page 55 (CNS)-B stated the licensee provided treatment management services to residents including assistance with oxygen, CPAP (continuous positive airway pressure), and blood glucose testing. R1 R1's service plan/care plan signed June 17, 2024, indicated R1 received services including assistance with CPAP machine and oxygen. R1's provider orders dated February 12, 2025, included: oxygen with CPAP at one liter for sleep. On March 13, 2025, at 11:42 a.m., the surveyor observed R1 seated in her recliner chair in her room; a CPAP machine and oxygen concentrator were within reach of the recliner. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On March 13, 2025, at 11:25 a.m., CNS-B reviewed R1's treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with the resident's oxygen or CPAP machine. R2 R2's service plan dated July 7, 2023, indicated R2 received services including blood glucose testing. R2's provider orders dated February 12, 2025, included: insulin glargine Solostar 300 unit/milliliter subcutaneous solutions pen injector. Inject 10 units subcutaneously once daily at	01940			

Minnesota Department of Health

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01940	Continued From page 56 bedtime. Hold if BS<100 (blood sugar less than 100). R2's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On March 12, 2025, at 2:36 p.m., CNS-B reviewed R2's treatment plan and stated it did not include clear direction to staff for blood glucose parameters and when to notify a nurse. The licensees undated, Individualized Medication, Treatment & Therapy Management Plans policy indicated: 6. Treatment and Therapy Management Plans: RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment and/or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	01960			

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01960	Continued From page 57 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's was admitted on July 1, 2022, with diagnoses including type II diabetes mellitus. R2's service plan dated July 7, 2023, indicated R2 received services including blood glucose testing. R2's provider orders dated February 12, 2025, included: insulin glargine Solostar 300 unit/milliliter subcutaneous solutions pen injector. Inject 10 units subcutaneously once daily at	01960			

Minnesota Department of Health

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01960	Continued From page 58 bedtime. Hold if BS<100 (blood sugar less than 100). R2's record did not include evidence blood glucose testing had been completed since November 12, 2024. On March 12, 2025, at 2:36 p.m., clinical nurse supervisor (CNS)-B stated R2 has been receiving insulin since admission. When asked why blood glucose testing was not been completed, CNS-B stated, "For some reason unknown to me stopped in November 2024". Upon investigation, CNS-B stated when the order was renewed there was a button under BG (blood glucose) that wasn't clicked in the system, so the BG prompt was not entered into the MAR (medication administration record). The surveyor reviewed R2's blood glucose values from January 1, 2025, through November 12, 2025; there were no values under 100. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	02040			

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02040	Continued From page 59 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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). Findings include: On March 12, 2025, at 11:25 a.m., licensed assisted living director (LALD)-C and director of maintenance (DM)-F provided documents on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had performed a hazard vulnerability assessment on and around the property that identified a roadway, pond and wooded area as potential hazards. The document lacked mitigation factors for the identified hazards.	02040			

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02040	Continued From page 60 During interview on March 12, 2025, at 12:04 p.m., LALD-C and DM-F verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of three residents (R5) observed during medication administration. 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:	02320			

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02320	Continued From page 61 R5's diagnoses included Alzheimer's disease, hypertension (high blood pressure), chronic pain, constipation, and mood disorder R5's provider's visit note dated February 12, 2025, included the following orders: -acetaminophen 325 mg (milligrams) oral tablet, take two tablets by mouth two times a day; -calcium antacid 500 mg oral tablet chewable, take one tablet by mouth three times a day; -CertaVite Senior oral tablet, take one tablet by mouth daily; -losartan potassium (for high blood pressure) 25 mg oral tablet, take one tablet daily; -mirtazapine (antidepressant) 15 mg oral tablet, take one tablet by mouth once daily; -sertraline (antidepressant) 50 mg oral tablet, take one tablet daily; -polyethylene glycol (for constipation) 3350 powder, mix one capful (17 grams) in liquid and take by mouth once daily. On March 11, 2025, at 8:26 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare the above scheduled morning medications for R5. ULP-E crushed the oral tablets and poured them and the polyethylene glycol powder into an individual 8 ounce high protein drink for R5 to consume. ULP-E brought the protein drink with the medications to R5's room and handed it to the resident and directed her to drink it. R5 took a couple sips, dribbled a small amount of the liquid down the front of her shirt, and ULP-E quickly intervened to wipe it off. ULP-E then directed R5 to keep working on drinking the protein drink with the medications and stated she would check on her in a little while to make sure she finished it. ULP-E then exited R5's room without watching and ensuring the resident consumed the	02320			

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02320	Continued From page 62 medications. On March 12, 2025, at 2:36 p.m., clinical nurse supervisor (CNS)-B stated staff were trained and expected, to remain with the resident when administering medications until all medications had been consumed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Minnesota Dept. of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza
Mankato, MN

Type: Full
Date: 03/12/25
Time: 11:51:07
Report: 1028251031

Food and Beverage Establishment Inspection Report

Page 1

Location:

Water'S Edge
800 Agency Trail
Mankato, MN56001
Blue Earth County, 07

Establishment Info:

ID #: 0039192
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073888582
ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

Provide a supply of paper towels at the handwashing sinks at the 1st, 2nd, and 3rd floor kitchen areas at all times.

Comply By: 03/12/25

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

The dish machines on the 1st, 2nd, and 3rd floor kitchens do not meet code for commercial food service equipment standards. These machines must be replaced with equipment that meets this standard.

Crock-pots on the 2nd floor kitchen must be removed.

Comply By: 03/12/25

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 40 Degrees Fahrenheit - Location: Arctic Air - Ambient

Violation Issued: No

Type: Full
Date: 03/12/25
Time: 11:51:07
Report: 1028251031
Water'S Edge

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Ham
Violation Issued: No

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

A Re-Inspection of the violations listed on this Report will be conducted on April 25th to ensure that compliance with these orders has been reached.

This Inspection was conducted in conjunction with HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028251031 of 03/12/25.

Certified Food Protection Manager Ryan Wieneke

Certification Number: FM52916 Expires: 04/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ryan Wieneke
Kitchen Manager

Signed:  _____

Ryan Miller
Environmental Health Specialist
MDH - Mankato
507-995-7672
Ryan.Miller@state.mn.us