Electronically Delivered

April 10, 2025

Licensee
Saint Therese at St.Odilia
3500 Vivian Avenue
Shoreview, MN 55126

RE: Project Number(s) SL27661016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 12, 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.

MDH 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.

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 . . ."

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

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.

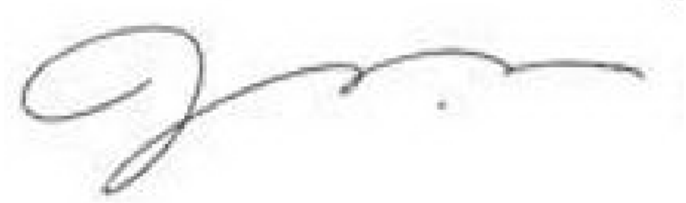
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27661	A. BUILDING: _____ B. WING _____	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE AT ST.ODILIA	3500 VIVIAN AVENUE SHOREVIEW, MN 55126

(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 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: SL27661016-0 On March 10, 2025, through March 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six (6) residents, all whom received services under the Assisted Living Facility license.	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		

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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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential 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) 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 March 10, 2025, from 1:08 p.m. to 2:35 p.m., the surveyor toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the tour the surveyor	0 790		

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0 790	Continued From page 4 observed the following: Supplied portable fire extinguishers throughout the facility lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. Annual inspection tags from Summit Protection were affixed to mounted extinguishers indicating current annual service as of January 2025, however the rear of the tag did not show monthly inspections by facility staff. No other documentation was provided regarding monthly extinguisher inspection. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. An extinguisher was located in a supply closet on the lower level that was equipped with a tag indicating that the last annual service of the extinguisher occurred in February 1993. Annual service is required for supplied extinguishers to maintain them in good working condition. During survey on March 10, 2025, the surveyor explained to LALD/CNS-A that the portable fire extinguishers must be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/CNS-A stated they were unaware of monthly inspection requirements and verified the findings. LALD/CNS-A stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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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 by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810		

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0 810	Continued From page 6 safety and evacuation plan with required content and provide required training and documentation. 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 10, 2025, at approximately 2:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP titled Saint Therese of St. Odilia Emergency Procedures Plan did not include adequate employee actions to be taken during a fire or similar emergency. LALD/CNS-A provided documents relating to emergency procedures for staff that were not fully developed and included information not relevant to the facility. The evacuation procedures listed in their plan titled Fire Drill Policy and Procedure included only a general plan and included the reference to fire protection features not present in their facility such as fire alarm pull stations, automatic self-closing doors and paging system. LALD/CNS-A stated that they recognized that the FSEP was not specific to facility, needed further	0 810		

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0 810	Continued From page 7 information detailing evacuation actions, and should be updated to remove references to equipment not present in the facility. LALD/CNS-A stated that updates to the FSEP are already in progress and deficient conditions noted by the surveyor would be incorporated into updated FSEP. The FSEP did not include fire procedures for residents. LALD/CNS-A explained that the current facility plan for residents is largely to shelter in place but was not able to provide any further information or any documentation. The FSEP should include fire procedures for residents. The FSEP did not include any documentation of trainings provided to residents on evacuation. Trainings should be made available to residents capable of assisting in their own evacuations at least once a year. LALD/CNS-A stated that, due to specific medical concerns, most residents were unable to assist in evacuation but indicated that such situation would be documented and those residents capable of assisting would receive documented training in the future. During the record review and interview on March 10, 2025, LALD/CNS-A verified the above listed documents were absent from the FSEP. LALD/CNS-A stated that they understood requirements and would develop resident fire procedures for staff and residents, and implement and record trainings with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 8	01290		
01290 SS=D	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 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 they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) 27661 for one of two employees (licensed practical nurse (LPN)-C). 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).	01290		

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01290	Continued From page 9 The findings include: The licensee's HFID was 27661. The licensee was the owner of a second facility HFID 27752. LPN-C was hired on April 24, 2018, to provide direct cares to residents. LPN-C was licensed as a practical nurse by the Minnesota Board of Nursing on November 29, 1993. Throughout the survey between March 10, 2025, and March 12, 2025, LPN-C provided medication administration and other services to various residents. On March 10, 2025, at 11:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated upon hire, the human resource department (HR) was responsible for completing background studies. At 2:32 p.m., by email, the surveyor received LPN-C's background study clearance dated October 19, 2018, under HFID 27752. On March 11, 2025, at 2:00 p.m., the surveyor observed the licensee's HFID 27661 NETStudy 2.0 report with LALD/CNS-A and executive director project management (EDPM)-G, which indicated LPN-C did not have a completed BGS. LALD/CNS-A explained upon hire, LPN-C was on-call for licensee's sister facility then began employment at this facility. They stated the human resource department (HR) was responsible for completing background studies	01290		

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01290	Continued From page 10 and affiliating staff and would look into it further. On March 11, 2025, at 2:15 p.m., EDPM-G stated LPN-C was not affiliated with licensee. They stated management needed to notify HR when an employee was transferred from a sister facility so HR could affiliate the staff person to the correct facility. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) last updated December 13, 2024, read, "If you have an existing background study for someone at one facility, you can affiliate the person's background study to another facility if the Sensitive Information Person (SIP) is the same." The licensee's Background Studies policy dated November 2, 2022, indicated all employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through Department of Human Services (DHS). The policy lacked direction that the background study must be affiliated with the licensee, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *03/10/25*
Time: 13:51:57
Report: 8058251056

Food and Beverage Establishment Inspection Report

Location:
St Therese Collaborative Llc
3500 Vivian Avenue
Shoreview, MN55126
Ramsey County, 62

Establishment Info:
ID #: 0038090
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6518426780
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.

3-800 Highly Susceptible Populations

3-801.11C ***** Priority 1 *****

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

SUNNY SIDE UP EGGS - SEE COMMENTS

Comply By: 03/10/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE 1
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE 2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TURKEY BREAST
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: HOT DOG
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *03/10/25*
Time: 13:51:57
Report: 8058251056
St Therese Collaborative Llc

Food and Beverage Establishment Inspection Report

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

UNPASTEURIZED EGGS CANNOT BE UNDERCOOKED PER REQUEST (E.G. SUNNY SIDE UP), FOR EGGS COOKED PER REQUEST IN THIS MANNER, USE PASTEURIZED EGGS ONLY

NON COMMERCIAL APPLIANCES AND FINISHES

HRD INSPECTOR ANNA BOHNEN

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058251056 of 03/10/25.

Certified Food Protection Manager: TAMARA DARNELL DAVIS

Certification Number: 48816 Expires: 09/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
TAMARA DARNELL DAVIS
PIC

Signed: _____
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