DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2023

Licensee
Summit Hill Senior Living
1824 Old Hudson Road
Saint Paul, MN 55119

RE: Project Number(s) SL28605015

Dear Licensee:

On April 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 2, 2022, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

Electronically Delivered

December 23, 2022

Licensee
Summit Hill Senior Living
1824 Old Hudson Road
Saint Paul, MN 55119

RE: Project Number(s) SL28605015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

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

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28605	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28605015 On November 28 through November 30, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 100 residents; 99 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code, and the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all residents of the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report, dated November 28, 2022, for additional Minnesota Food Code deficiencies. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; 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	0 485		

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0 485	Continued From page 3 Food Code, and the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruits and vegetables. The licensee further failed to inform residents, in advance, of menu changes. This had the potential to affect all 100 residents of the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1, R2, and R5's Assisted Living Contract, each signed August 1, 2021, indicated R1, R2, and R5 all participated in the licensee's monthly meal plan to receive three meals per day. On November 28, 2022, at 10:26 a.m., a monthly meal menu was observed posted in the lobby area outside the assisted living director (ALD)-B's office. On November 28, 2022, at 11:06 a.m., unlicensed personnel (ULP)-H stated there were problems with the kitchen, the food was not good, and the residents complained about the food often. On November 30, 2022, at 9:38 a.m., a menu for the month of November was observed posted in R5's room. The menu indicated lunch for that day would include a "club sandwich" and "cold pasta".	0 485		

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0 485	Continued From page 4 On November 30, during a 9:46 a.m. interview, R5 stated the scheduled meal indicated on the menu was changed approximately 50% of the time. R5 further stated residents did not find out about menu changes until they arrived in the dining room and read the meal order ticket on the table. R5 further stated the food portions were small, the food served was often greasy, too salty, and only included vegetables "sometimes", and often "starchy vegetables like french fries and corn". R5 indicated he had to buy additional food because there was not enough. and the food was often unhealthy or unappetizing. R5 indicated sometimes not enough of the planned menu items were available to serve all the residents, and stated, "You go down for meal, and before it's over we are told they have run out". R5 stated the food issue was the issue that raised the most concern and disappointment, and residents participated in a monthly "food panel", led by the activities director, and complained at resident council meetings, but nothing had changed. R5 asked, "Are we really able to have any kind of influence?" R5 further stated there was no management present on the weekends so kitchen staff "do what they want, and we have to put up with it". On November 30, during a 10:15 a.m. interview, R1 stated the menu changed about 70% of the time, and residents would find out about menu changes when they arrived in the dining room to eat. R1 further stated they served vegetables, but they were "soggy, and mush". R1 stated "you could drink them, they are so soft". R1 further stated, "If it's something good, if you get to the dining room at 5:10 you won't get what's on the menu. They will serve something entirely different." R1 further stated, "This food and this place are not what I want." and "I have gone to	0 485		

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0 485	Continued From page 5 the meetings, but nothing changes." On November 30, 2022, at 10:49 a.m., the surveyor requested a meal order ticket for the upcoming lunch. The order ticket indicated lunch, starting at 12:00 p.m., was coconut shrimp and "chips", rather than the club sandwich and cold pasta as indicated on the monthly menu given to residents. -at 10:51 a.m., R1 stated this was the first he became aware of the menu change. -at 10:56 a.m., ULP-G stated the residents that go down to the dining room to eat would see the menu changes when they got to their table. -at 11:08 a.m., R5 was in the common area outside the dining room. R5 stated he had just become aware of the change to the menu. On November 30, 2022, at 11:50 a.m., the dining room opened and lunch service started. -at 12:00 p.m., R13 stated the menu was changed "almost daily", and residents did not find out about changes until they sat down at their table. R13 further stated residents were served small portions and the kitchen frequently ran out of food. R13 further stated the fruit and vegetables were canned and residents were often served french fries and potatoes and other foods high in carbohydrates and fat. -at 12:11 p.m., R13 was served breaded shrimp and potato chips with a lettuce salad in an approximately 1 cup Styrofoam bowl. The lettuce appeared wilted. R13 requested cocktail or tartar sauce from unidentified kitchen staff. The staff told R13 cocktail or tartar sauce was not available. -at 12:17 p.m., R2 was served breaded shrimp and potato chips, approximately 1/4 cup of cantaloupe, and approximately 1 cup of vegetable pasta soup. R2 stated she was able to get both	0 485		

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0 485	Continued From page 6	0 485		

the cantaloupe and the soup only because she had made friends with some of the kitchen staff. R2 further stated residents got very excited to go out to eat with family because the food was not good, and residents would "congratulate each other when they were able to go out to eat".
-at 12:30 p.m., R15 stated the food served to residents was often breaded and had a high fat content. R15 further stated they were not served what was on the monthly menu, and often were not served vegetables or fruit. R15 further stated the licensee provided bagged snacks in a bowl in the common area and "Nine times out of ten, there's no snacks available for everyone else because somebody took them all."
-at 12:43 p.m., unidentified residents at table 3 stated the food was good that day. The residents stated it was hot that day, but is usually cold and of poor quality, such as "Swedish meatballs that were hard and served with no gravy". An unidentified resident at the table stated if they complained, the staff would get angry with them.
-at 12:51 p.m., R16 stated she had to buy her own food because they didn't serve enough. R16 stated she had seen staff carrying out bags of Styrofoam containers after meals.

On November 30, 2022, at 1:03 p.m., dietary aid (DA)-H stated they had been working at the facility for about 6 weeks. DA-H indicated they did not know who was in charge of the kitchen.

On November 30, 2022, at 1:46 p.m., ALD-B stated they currently had no kitchen director, and director of maintenance (DM)-D was currently overseeing the staff hiring and food ordering. ALD-B stated they did receive many complaints and food was often discussed at resident councils. ALD-B indicated they tried to address the residents' concerns. ALD-B further stated

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0 485	Continued From page 7 there had been a lot of staff turnover in the kitchen so most of the kitchen staff were new and both ALD-B and DM-D were often busy with their other duties. On November 30, 2022, at 2:59 p.m., DM-D, who was the interim culinary manager, stated he was hired August 2020 and was the culinary director for the facility for about 5-6 months before becoming the maintenance director. DM-D stated the monthly meal menu was "subject to change", and menu changes happened maybe 2-3 times per month, and were often due to supply issues and ordered items not being delivered. DM-D further stated residents would typically learn about menu changes the same day as the meal. DM-D stated he would normally indicate the change by crossing off the item and writing the substitution on the menu posted in the common area outside ALD-B's office, but that day, by the time he realized there would be a substitution, it was too late to update the menu. DM-D indicated residents were served a choice of fruit, soup, or salad at each meal. DM-D stated there were many new staff and he was available to be fully present in the kitchen at least twice a week, but many days was busy with other duties. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 8 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide minimum emergency generator system inspections as part of the emergency plan required under Minnesota Rules, Part 4659.0100 to ensure the proper performance of the generator. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 9 or has potential to affect a large portion or all of the residents). The findings include: On November 29, 2022, at approximately 2:00 p.m., survey staff requested records relating to the emergency generator inspections, maintenance, and load test runs for review from maintenance director (DM)-D. Document review and interview with DM-D and assisted living director (ALD)-B at approximately 3:00 p.m., indicated the licensee failed to provide the required minimum frequency of weekly inspection records to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. DM-D provided documentation of the monthly load test runs and the annual service performed by their generator contractor, dated 12/16/2021, but no weekly inspection records or documentation were available for review. On November 29, 2022, at approximately 3:15 p.m., ALD-B and DM-D acknowledged the finding that the weekly inspections on the emergency generator were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 10 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a working smoke alarm in resident apartment unit 704 and the interconnection requirement of the smoke alarms inside the one-bedroom living units located throughout the facility. This has the potential to directly affect 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	0 780		

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0 780	Continued From page 11 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 November 29, 2022, approximately from 11:10 a.m. to 1:50 p.m., survey staff toured the facility with maintenance director (DM)-D. During the tour, survey staff observed and DM-D verified the following when the smoke alarms were tested: 1) Inside the studio resident living unit 704, the required smoke alarm was missing from its housing. The finding was evident as wires were exposed and DM-D stated that the resident must have removed it but he can locate a spare smoke alarm and re-installed it immediately. 2) The smoke alarms located in the one-bedroom units throughout the facility were not interconnected as required. The finding was evident as DM-D tested each smoke alarm of the one-bedroom units and each alarm sounded local and failed to sound the other smoke alarm for proper notification. DM-D verified the finding and stated that all the one-bedroom unit types throughout are not interconnected. On November 29, 2022, at approximately 3:15 p.m., during the exit interview, DM-D and assisted living director (ALD)-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 780		

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0 800	Continued From page 12	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. 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). On November 29, 2022, approximately from 11:10 a.m. to 1:50 p.m., survey staff toured the facility with maintenance director (DM)-D. During the tour, survey staff observed and DM-D verified the following: 1) In resident living unit 604, the bathroom exhaust fan was layered with dust and the bathroom floor was dirty. 2) In resident living unit 211, the exhaust fan was	0 800		

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0 800	Continued From page 13 not working. 3) In resident living unit 704, the carpet flooring was soiled and stained. In addition, the filter and the surfaces on the electrical cooling and heating unit (PTAC) were dirty, sticky, and greasy. 4) In resident living units 106, 114, 218, 418, 501, 506, 604, 609, 612, 702, and 704, the PTAC air filters were layered with dust. In addition, resident room 301 was missing an air filter. 5) No records were available for review to ensure the annual testing of the reduced pressure zone backflow preventer and boiler/hot water storage tanks were performed. 6) Magnetic door holders for the set of fire-rated doors (1-1/2 hour) located next to the activity room were not connected to the fire alarm system to release automatically during a fire to ensure the proper functioning of the fire-rated doors. Survey staff explained that the 1-1/2-hour fire-rated doors need to be in proper working order to maintain the integrity of the fire safety plan and doors must be able to close automatically to compartmentalize the building during a fire. 7) The fire-rated door to the sprinkler riser room (hot water storage tanks and other mechanical equipment) failed to positively latch when closed. In addition, the door failed to lock to protect residents and other unauthorized entry. 8) The chemical soap dispenser connected to the faucet of the mop sink located in the back hallway of the main kitchen on the first floor lacked a pressure bleeding device to properly prevent cross-connection of chemicals to the building water supply system and must be consulted with a local authorized contractor/installer for code-compliant installation. On November 29, 2022, at approximately 3:15 p.m., during the exit interview, DM-D and the	0 800		

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0 800	Continued From page 14 assisted living director-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at the facility. 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:	0 970		

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0 970	Continued From page 15 On November 28, 2022, at 10:30 a.m., during the entrance conference, the licensee provided a survey binder that included the licensee's current Assisted Living Contract. The licensee's Assisted Living Contract, included the following language indicating a waiver of liability: Page 12, section 23 "Indemnification": "As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal Injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents." On November 29, 2022, at 12:48 p.m., assisted living director (ALD)-B stated they were aware of the waiver of liability in the contract. ALD-B further stated the contract was in the process of being updated. ALD-B stated all residents currently had the version of the contract that included the waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 16 (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) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (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	01620		

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01620	Continued From page 17 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 service plan, dated October 19, 2021, indicated R1 received services including assistance with blood glucose monitoring, activities of daily living (ADLs), shower, housekeeping, laundry, and medication management. R1's record included a nursing assessment completed August 18, 2022, and a reassessment completed November 21, 2022, greater than 90 days after the previous assessment. On November 29, 2022, at 1:18 p.m., RN-A stated there were no assessments completed for R1 between the dates indicated. RN-A stated it is their policy to complete assessments every 90 days. RN-A further stated a reminder should indicate to the RNs when an assessment was due. The licensee's Assessments, Reviews, and Monitoring policy, dated August 1, 2021, indicated, "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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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02040	Continued From page 18	02040		
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 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On November 29, 2022, at approximately 2:00	02040		

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02040	Continued From page 19 p.m., survey staff received the facility's hazard vulnerability assessment plan, undated, Hazard and Vulnerability Assessment Tool. The review of the documentation indicated the following: 1) The licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the memory care residents from harm. This finding was evident as the documentation did not include site-specific safety risks relating to memory care assessment. 2) The documentation did not include mitigations to protect memory care residents from harm. Prevention measures and/or mitigations must be developed and documented in the plan. On November 29, 2022, at approximately 3:00 p.m., survey staff discussed the findings and explained to assisted living director (ALD)-B and maintenance director (DM)-D that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. ALD-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the	02090		

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02090	Continued From page 20 provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to maintain a dignified dining experience by using appropriate tableware in the dining room. This had the potential to affect all of the licensee's 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's Assisted Living Contract, each signed August 1, 2021, indicated R1, R2, and R5 all participated in the licensee's monthly meal plan to receive three meals per day. On November 30, 2022, at 9:17 a.m., R5 indicated food was often served in Styrofoam bowls and takeout containers in the dining room. R5 stated they complained at meetings, but nothing changed, and "Are we really able to have any kind of influence?" R5 further stated there was no management present on the weekends so kitchen staff "do what they want, and we have to put up with it". On November 30, during a 10:15 a.m. interview,	02090		

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02090	Continued From page 21 R1 stated residents were served food in Styrofoam containers with plastic utensils. R1 stated "they just started using silverware when you guys showed up." R1 indicated it made him sad, and stated, "we shouldn't be treated that way." On November 30, 2022, at 10:56 a.m., unlicensed personnel (ULP)-G stated meals were served in Styrofoam containers with plastic utensils. When asked again, ULP-G stated residents in the dining room were served meals on glass plates. On November 30, 2022, at 11:50 a.m., the dining room opened and lunch service started. -at 11:53 a.m., R2 stated the silverware is typically plastic, and they started using metal silverware just that week. R2 further stated they usually served food in Styrofoam "to-go" containers. -at 12:11 p.m., R13 was served breaded shrimp and potato chips on a glass plate with a lettuce salad in an approximately 1 cup-sized Styrofoam bowl. -at 12:17 p.m., R2 was served breaded shrimp and potato chips on a glass plate, and approximately 1/4 cup of cantaloupe, and approximately 1 cup of vegetable pasta soup, each in a 1 cup-sized Styrofoam bowl. R2 stated the entree was on a glass plate today because surveyors were present. -at 12:25 p.m., R12 was served lunch including a lettuce salad with chicken. The meal was served in a Styrofoam takeout-style container. R12 stated he did not request the meal "to go". -at 12:43 p.m., an unidentified resident seated at table 3 stated sometimes food is served on glass plates, but, "if they are busy or short of staff they will use Styrofoam". The resident further stated,	02090		

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02090	Continued From page 22 "if we complain, they will argue and threaten us." -at 12:51 p.m., R16 was observed eating lunch out of a Styrofoam container. R16 stated the food was always served in Styrofoam containers. On November 30, 2022, at 12:00 p.m., surveyor observed the memory care residents eating lunch in the memory care unit dining room. Residents were served breaded shrimp, french fries, and green grapes. The residents were not provided silverware, or napkins. On November 30, 2022, at 1:03 p.m., dietary aid (DA)-H stated food was usually served in Styrofoam containers. On November 30, 2022, at 1:46 p.m., assisted living director (ALD)-B confirmed they had recently received an order of metal silverware for the kitchen and started using it that week. ALD-B further stated staff should only be using Styrofoam containers for to-go meals, but they were currently using Styrofoam bowls in the dining room because they did not have enough glass bowls. ALD-B further stated the glass bowls were ordered but had not been delivered. On November 30, 2022, at 2:59 p.m., DM-D, who was the interim culinary manager, stated they had run short of glass dishes to use, and did not know why. DM-D agreed using Styrofoam was a dignity issue, and indicated they had ordered new glass dishes. DM-D further stated he was aware some kitchen staff had used to-go containers for convenience, but the issue was being addressed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02090		

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02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R11). This had the potential to cause harm to R11. 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 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: R11 started services on October 19, 2021. R11's diagnoses included but were not limited to, diabetes mellitus type II with unspecified diabetic retinopathy, and end stage renal disease. On November 30, 2022, at 12:00 p.m., surveyor observed the residents of memory care eating lunch in the dining room. Residents were served breaded shrimp, french fries, and green grapes.	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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
02310	Continued From page 24 Surveyor asked R11 why he was not eating his shrimp and R11 stated, "I am allergic to shellfish, so I am not going to eat the shrimp." R11's medication administration record dated November 2022, indicated R11 had allergies to include: IV (intravenous) contrast dye, codeine, lisinopril, metformin, Shellfish, and spironolactone. On November 30, 2022, at 2:23 p.m., R11 stated they would experience gastrointestinal (stomach) upset from eating shellfish. On November 30, 2022, at 2:35 p.m., unlicensed personnel (ULP)-E stated, "We do not know if a resident is allergic to something until the resident complaints of an upset stomach, and then we report it to the nurse". On November 30, 2022, at 2:59 p.m., maintenance director (DM)-D stated, "In memory care, we would expect the aids to be aware of the food allergy in the care plan." DM-D stated there was an allergy list in the kitchen, but there should also be an allergy list posted in the memory care unit so staff would be better aware of food allergies. On November 30, 2022, at approximately 4 p.m., registered nurse (RN)-A confirmed no allergy list was posted in the memory care unit of the licensee for staff review, and no resident allergy lists were provided to dietary staff. The licensee's ALDC Additional Dementia Staff Training policy dated as revised on August 1, 2021, indicated the staff would be trained to provide a person-centered care approach for residents.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28605	A. BUILDING: _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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
02310	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *11/28/22*
Time: 11:07:16
Report: 8058221232

Food and Beverage Establishment Inspection Report

Location:
Summit Hill Senior Living
1824 Old Hudson Road
St Paul, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0039186
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517679572
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

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

EGGS NOT PASTEURIZED

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

CUTTING SURFACE AT PREP COOLERS DARKENED FROM USE - CLEAN OR REPLACE

Comply By: 12/19/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

EQUIPMENT HANDLES, FACES, DOORS SHOW ACCUMULATION OF DEBRIS

Comply By: 12/12/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN FLOORS WALLS AND CEILINGS (HVAC VENTS)

Comply By: 12/19/22

Surface and Equipment Sanitizers

Hot Water: = at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: YOGURT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: GRAPES
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BEEF
Temperature: 167 Degrees Fahrenheit - Location: REHEATED FOR HOT HOLD
Violation Issued: No

Process/Item: CHICKEN
Temperature: 206 Degrees Fahrenheit - Location: HOT HOLD
Violation Issued: No

Process/Item: GROUND BEEF
Temperature: 41 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

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

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

Food and Beverage Establishment Inspection Report

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 8058221232 of 11/28/22.

Certified Food Protection Manager CUYLER KAPPENMAN

Certification Number: 103358 Expires: 02/20/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
CUYLER KAPPENMAN
PIC

Signed: 
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us