



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 5, 2022

Administrator
The Legacy of St. Anthony
2540 Kenzie Terrace
Saint Anthony, MN 55418

RE: Project Number SL29719015

Dear Administrator:

On June 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 24, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 24, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 24, 2022, found not corrected at the time of the June 7, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 - \$500.00

The details of the violations noted at the time of this follow-up evaluation completed on June 7, 2022 (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 \$500.00.** You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

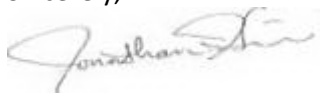
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-592-5119.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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: 651-592-5119 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL29719015-1 On June 7, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 24, 2022. At the time of the survey, there were 36 residents; 26 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 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 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
{0 480}	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: No further action required.	{0 480}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (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	{0 780}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
{0 780}	Continued From page 2 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: No further action required.	{0 780}		
{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: No further action required.	{0 790}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
{0 810}	Continued From page 3 (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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 4 (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 the resident service plan included the required content for three of three residents (R3, R1, R4,) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{01650}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Resident Service Plans dated January 26, 2022, for R3; February 18, 2022, for R1; and February 22, 2021, for R4 indicated the resident's received assistance with activities of daily living (ADL) and medication management. R3, R1, and R4's service plans lacked the following: -schedule and method of monitoring assessments of the resident. -schedule and methods of monitoring staff providing services; and -a contingency plan that included the action to be taken if the scheduled service could not be provided. On June 7, 2022, at 11:00 a.m., director of nursing (DON)-C verified the resident service plan agreement lacked the required content noted above. DON stated that she was in contact with the Eldermark (documentation system) staff and requested to change the services plan, service plan were not changed. The licensee's Contents of Service Plans policy dated January 3, 2020, noted the service plan would include, the schedule and methods of monitoring reviews or reassessments of the resident, the frequency of supervision of staff providing services and the identification of the supervisor(s) who will be providing the	{01650}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/07/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY			STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 6 supervision, and a contingency plan. No further information was provided.	{01650}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 5, 2022

Administrator
The Legacy of St. Anthony
2540 Kenzie Terrace
Saint Anthony, MN 55418

RE: Project Number(s) SL29719015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - 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 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

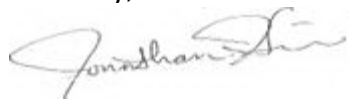
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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: 651-592-5119 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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: SL29719015 On March 21, 2022 through March 24, 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 40 residents; 36 receiving services under the provider's Assisted Living license. On March 22, 2022, at approximately 2:17 p.m. an immediate correction order was written at 2310. On March 23, 2022, the immediacy was removed, the scope and level remain the same.	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 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 480	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 according to the Minnesota Food Code. 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 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 480	Continued From page 2 Inspection Reports, dated March 21, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 650	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees unlicensed personnel (ULP)-B with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: Unlicensed personnel (ULP)-B's employee record showed ULP-B had a rehire date of November 30, 2021. ULP-B's employee record did not contain a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On March 23, 2022, at approximately 11:00 a.m., director of nursing (DON)-C confirmed the ULP-B's record lacked a job description with the required content. The licensee's "The Legacy of St. Anthony Assisted Living Policies and Procedures" personnel files/employee record policy dated July 01, 2021, noted the employee record would include a current job description, including qualifications, responsibilities and identification of supervisors. No further information was provided.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 650	Continued From page 4	0 650		
0 780 SS=E	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.45 Subd. 2 (a) (1) Fire protection and physical environment (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 maintain proper functioning of the smoke alarm in resident room #202 and failed to provide interconnection of smoke alarms in room #410 as required by Minnesota Statutes, 144G.45, Subd.	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 780	Continued From page 5 2. This has the potential to directly affect all assisted living residents, visitors, 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, 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: On March 24, 2022, between the hours of 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the director of maintenance (DM)-H. RESIDENT ROOM #410 On March 24, 2022, at approximately 11:10 a.m., survey staff observed the smoke alarms in the two-bedroom resident room #410 were tested by the DM-H. The smoke alarm located inside the sleeping room failed to sound when the alarms located outside of the sleeping room and in the den were tested. This finding was verified by the DM-H as he stated that room #410 was remodeled into a two-bedroom room by combining two separate rooms (410 and 412), and probably did not connect the smoke alarms at that time. Survey staff explained that all smoke alarms in room #410 must be interconnected, as well as alarmed such as when the actuation of one smoke alarm causes both to sound for notification. RESIDENT ROOM #202 On March 24, 2022, at approximately 11:45 a.m., survey staff observed the smoke alarm in resident room #202 was disconnected and dismantled. This finding was verified by the DM-H.	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 780	Continued From page 6 On March 24, 2022, at approximately 12:45 p.m., the DM-H, the executive director-D, and the director of nursing-C, acknowledged the above findings at the exit interview. The DM-H explained that the dismantled smoke alarm in room #202 has been taken care of already. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents, visitors, 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	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 790	Continued From page 7 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 24, 2022, between the hours of 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the director of maintenance (DM)-H. Survey staff observed portable fire extinguishers located throughout the 4-story building including the lower level and main kitchen were tagged indicating the annual service date of November 2021, but all lacked records to show the required monthly visual inspections. DM-H confirmed the findings as he stated he was not aware of the visual monthly inspections required on portable fire extinguishers. Survey staff explained that the monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. On March 24, 2022, at approximately, 12:00 p.m., survey staff observed the indicator needle inside the gage of the stainless-steel portable fire extinguisher (located in the main kitchen) was in the red zone and needed to be serviced and/or recharged. On March 24, 2022, at approximately 12:45 p.m., the DM-H, the executive director-D, and the director of nursing-C acknowledged the above findings at the exit interview.	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 790	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 810	Continued From page 9 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required evacuation drills, and the required training of staff on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving 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), 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 24, 2022, between the hours of 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the director of maintenance (DM)-H. On March 24, 2022, at approximately 10:10 am, survey staff received the facility fire safety and evacuation plan and related documentation for review. FIRE SAFETY AND EVACUATION PLAN -The documentation lacked employee actions to be taken in the event of a fire or similar emergency. The facility's fire policy (undated), section 412 (page 36), incorrectly adopted language referring to a tornado event, "lie flat in the nearest ditch or culvert" or "taken shelter in the bathroom". -The documentation lacked the specific fire	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 810	Continued From page 10 protection procedures and planning necessary for addressing all residents including any unique or unusual resident needs including memory care residents during an evacuation. Unique resident-specific needs may include cognitive impairment, wheelchair-bound, on walkers, non-ambulatory, bedridden, and needing assistance during an evacuation, -The documentation lacked fire protection procedures for the residents. TRAINING The policy documentation (undated), Staff Testing and Training Plan (page 15), included the minimum required content of employee training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter, but the licensee lacked documented records of employee training to show employee training has been performed per their adopted policy. FIRE and EVACUATION DRILLS The documentation lacked records of fire and evacuation drills to show compliance with state requirement of fire and evacuation drills at least twice per year per shift, with at least one evacuation drill every other month. Fire drills and evacuation drills may be combined when conducting drills. On March 24, 2022, at approximately 12:45 p.m., the DM-H, the executive director-D, and the director of nursing-C acknowledged the above findings at the exit interview. Survey staff suggested that all training and evacuation drills be recorded and/or documented. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 810	Continued From page 11 (14) days	0 810		
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 facility's liability for health, safety, or personal property of a resident, with four of four residents (R3, R1, R4, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 21, 2022, at approximately 12:00 p.m. executive director (ED)-D provided licensee's admission packet and stated all residents receive the admission packet upon the date of move-in. ED-D stated all residents used the Assisted Living	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 970	Continued From page 12 Contract. On page 14 under, 2. Indemnification, 3. Insurance, and 4. Liability. The admission packet included a description of renters insurance policy document, Renters Insurance Addendum, and State Farm Insurance pamphlet all of which indicated the licensee was not liable for personal injury or personal property of the resident Additionally on page nine (9) of the Assisted Living Contract under, "11. Resident Handbook," the contract indicated the residents received and will abide by the handbook. In the Resident Handbook on page five (5) under, "Renter's Insurance," the licensee indicated the resident is responsible for personal property as licensee's insurance does not cover personal property within the building. On record review, Assisted Living Contracts dated: July 22, 2021 for R1 and R4; July, 30, 2021 for R3; October 21, 2021, for R2 contained language waiving liability indicated " Provider is not liable to Resident or Resident's guest for any injury, death or property damage occurs the result of equipment malfunction or hazardous conditions with the building". On March 23, 2022, at approximately 11:00 a.m. ED-D and director of nursing (DON)-C verified resident's Assisted Living Contract included language which waived liability of the licensee. ED-D indicated language with waiver of liability was included in every resident's records within their respected assisted living contract. ED-D verified the licensee was not aware of the prohibition of a liability waiver. No further information provided. TIME PERIOD FOR CORRECTION:	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
0 970	Continued From page 13 Twenty-One (21) days	0 970		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A hired February 7, 2022, and began providing services at that time.	01460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01460	Continued From page 14 RN-A's employee record did not contain documentation of orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On March 21, 2022, at approximately 12:41 p.m., RN-A confirmed she had not completed assisted living requirement orientation for the licensee. On March 23, 2022, at approximately 11:00 a.m., executive director (ED)-D and director of nursing (DON)-C verified RN-A's record lacked documentation of any orientation or training provided by licensee. DON-C stated RN-A was requested to begin providing services immediately as licensee was transitioning a new administration team at RN-A's time of hire. The licensees 2.16 Orientation policy dated July 1, 2021, indicated employees would obtain all required orientation and training prior to performing any functions of their position. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01530	Continued From page 15 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff providing services completed dementia training within 160 working hours for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01530	Continued From page 16 RN-A hired February 7, 2022 and began providing services at that time. RN-A's employee record lacked evidence of completion of a total of eight hours of the required dementia training. On March 21, 2022, at approximately 12:41 p.m., RN-A stated she had not completed any dementia training from the licensee On March 23, 2022, at approximately 11:00 a.m., executive director (ED)-D and director of nursing (DON)-C confirmed RN-A's training record lacked documentation of any dementia training provided by licensee and RN-A had worked for 192 hours for licensee. DON-C stated RN-A was requested to begin providing services immediately as licensee was transitioning a new administration team at RN-A's time of hire. The licensee's 3.11 Dementia Training policy dated July 1, 2021, indicated employees would complete the required eight (8) hours of dementia training within 160 hours of employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01640	Continued From page 17 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plan and any revisions included a signature or other authentication by the resident and the licensee to document the agreement on the services to be provided for three of four residents (R3, R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01640	Continued From page 18 The findings include: Resident records included a signed Service Plan Agreement dated January 26, 2022 for R3; February 18, 2022 for R1; and February 22, 2021 for R4. The residents' records included recent Service Plan and Agreements with the same print date of March 22, 2022 for R3, R1, R4. The March 22, 2022, printed agreements identified and included service plan modifications and/or addition of services. The records lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provided by licensee after addition of services. On March 23, 2022, at 11:00 a.m. director of nursing (DON)-C stated R3, R1, R4's current service plans were not signed by resident or resident's representative. DON- C confirmed the updates were not acknowledged by the residents or resident's representative, by signing the updated service plans. The licensee's "The Legacy of St. Anthony Assisted Living Policies and Procedures" policy dated July 1, 2021, indicated, "The service plan and any revisions shall include a signature or other authentication by The Legacy of St. Anthony and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 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 the resident service plan included the required content for four of four residents (R3, R1, R4, R2) with records reviewed. This practice resulted in a level two violation (a	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Resident Service Plan dated January 26, 2022 for R3; February 18, 2022, for R1; February 22, 2021, for R4; and March 04, 2022, for R2. The current service plans indicated the residents received assistance with activities of daily living (ADL) and medication management. R3, R1, R4, and R2's service plans lacked the following: -schedule and method of monitoring assessments of the resident. -schedule and methods of monitoring staff providing services; and -a contingency plan that included the action to be taken if the scheduled service could not be provided. On March 23, 2022, at approximately 11:00 a.m. director of nursing (DON)-C verified the resident service plan agreement lacked the required content noted above. The licensee's Contents of Service Plans policy dated January 3, 2020, noted the service plan would include, the schedule and methods of monitoring reviews or reassessments of the resident, the frequency of supervision of staff providing services and the identification of the supervisor(s) who will be providing the	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 21 supervision, and a contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=D	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 management services; and (7) any resident-specific requirements relating to	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01730	Continued From page 22 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 two of four residents (R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 and R4's individualized medication management plan lacked the following: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01730	Continued From page 23 - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services. Resident Medication Self Administration form dated January 07, 2021 for R1, and April 21, 2021 for R4 indicated residents received assistance with medication management. On March 23, 2022, at approximately 11:00 a.m. DON-C confirmed the required content was missing the person responsible for refills, tasks to be delegated to ULP, and procedures for staff to notify a health professional if problems arose. The licensee's 5.37 Medication Management Individualized Plan policy dated July 01, 2021, indicated the resident's assessment must contain identification person responsible for refills, tasks to be delegated to ULP, and procedures for staff to notify a health professional if problems arose. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 24 instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may 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	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 25 designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. The licensee failed to ensure one of one employee (ULP-B) was trained and demonstrated competency to the RN to prepare and give medications for residents having unplanned time away. 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: During the entrance conference on March 21, 2022, at approximately 10:40 a.m. director of nurses (DON)-C confirmed the licensee provided	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 26 medication management services to most residents at the facility. ULP-B's records lacked evidence to indicate the RN provided training and determined competency to prepare medications to residents for unplanned times away. On March 21, 2022, at approximately 11:00 a.m., RN-A and DON-C confirmed ULP-B record lacked training and determined competency to prepare medications for residents having unplanned time away from the facility. DON-C stated she was aware ULP staff needed to be trained and demonstrate competency to the RN. The licensee's 5.11 Medication Administration - Planned and Unplanned Time Away policy dated July 01, 2021, indicated, ULP would be trained and found competent for providing medications for unplanned time away. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01890	Continued From page 27 Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of four residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: On March 22, 2022, at 8:30 a.m., the surveyor observed registered nurse (RN-A) assist R2 with blood glucose monitoring (blood sugar levels). R2's prescribed Lispro Kwik pen insulin pre-filled pen and Glargine Lantus insulin pre-filled pen (used to treat diabetes) lacked the date the pen had been opened, and when the pen would expire. On March 22, 2022, at 8:30 a.m. RN-A and director of nursing (DON)-C confirmed R2's insulin pens lacked the date the pen had been opened, and when the pen would expire. RN-A stated the medication labeling process was for the insulin pens to have the date filled out by staff, when first taken out of the medication refrigerator for use. The licensee's 5.24 Insulin policy dated July 01, 2021, lacked identification that a process of labeling and dating all resident insulin pre-filled pens was required when they are first opened.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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
01890	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R6) who utilized siderails with records reviewed. This resulted in an immediate order issued at 2310, on March 22, 2022, at approximately 2:17 p.m. 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 include: The Food and Drug Administration (FDA)	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 29 guidelines, titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment,	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 30 dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4. Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth. Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches. Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches. Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle. Zone 5, 6, and 7 are identified as potential for entrapment with the least reporting. Zone 5 is the area between the split of bedrails, zone 6 is the	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418		
(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 31 between the end of rail and the side edge of the head or footboard, and zone 7 is between the head of footboard at the end of the mattress. On March 22, 2022, at approximately 7:30 a.m. unlicensed personnel (ULP)-E provided R6's morning care included assist with transfer, dressing, grooming, brushing teeth, and feeding. R6's hospital bed had adjustable side rails on both sides, which were attached to the bed. The siderails were "U" shaped. The surveyor grasped the siderails and noted the siderails were secured to the bed and did not move when pulled and pushed on with force. The surveyor did not observe a gap between the siderails and R6's mattress. R6 admitted on January 24, 2020, with diagnoses including dementia, cellulitis of right lower limb, hyperlipidemia, peripheral artery disease, and depression. R6's MN Comprehensive Nursing and Service Plan Evaluation, dated January 20, 2022, indicated R6 required total assistance with transfers. R6's unsigned service plan, dated March 22, 2022, indicated R6 received services including medication management and activities of daily living. R6's medical record lacked documentation of a siderail assessment, education of the risks and benefits associated with the use of siderails, and measurements of the siderails. On March 22, 2022, at approximately 12:00 p.m., director of nursing (DON)-E acknowledged siderails are in place for R6. DON-E	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/24/2022
NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST ANTHONY		STREET ADDRESS, CITY, STATE, ZIP CODE 2540 KENZIE TERRACE SAINT ANTHONY, MN 55418			
(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 32 acknowledged R6's record would not contain functional ability assessments indicating the presence of siderails, documentation of siderail education of risks, or consent for the use of siderails. The licensee's Side Rails policy dated July 01, 2021, indicated the licensee shall assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy indicated it will be followed regardless of who owns or supplies the siderail. On March 22, 2022, at approximately 2:17 p.m. an immediate correction order was written at 2310. On March 23, 2022, the immediacy was removed, the scope and level remain the same. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310			

Type: Full
Date: 03/21/22
Time: 13:08:52
Report: 7958221059

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Legacy Of St Anthony
2540 Kenzie Terrace
St Anthony, MN55418
Hennepin County, 27

Establishment Info:

ID #: 0037584
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128433700
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SEVERAL HALF GALLONS OF MILK IN COOK LINE UPRIGHT REFRIGERATOR WERE AT 48 DEGS F. EXEC CHEF IMMEDIATELY DISCARDED ALL MILK THAT WAS STORED IN UNIT.

Comply By: 03/21/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

CONCENTRATION OF SANITIZER IN WIPING CLOTH BUCKETS WAS 0PPM. QUAT DISPENSER IS PROPERLY WORKING. ENSURE CLOTH TOWELS ARE PRE-SOAKED IN SANITIZER SOLUTION BEFORE PLACING IN FRESHLY FILLED WIPING CLOTH BUCKETS.

Comply By: 03/21/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

UPRIGHT REFRIGERATOR ON COOK LINE IS NOT RUNNING AT 41 DEGS OR LESS. EITHER ADJUST CONTROLS TO LOWER TEMP OR IF NECESSARY, HAVE UNIT SERVICED SO IT HOLDS ALL FOODS AT 41 DEGS OR LESS.

Comply By: 03/21/22

Type: Full
Date: 03/21/22
Time: 13:08:52
Report: 7958221059
The Legacy Of St Anthony

Food and Beverage Establishment Inspection Report

Page 2

Surface and Equipment Sanitizers

Wash temperature gauge: = at 134 Degrees Fahrenheit
Location: Jackson dish machine
Violation Issued: No

Final rinse temperature ga: = at 186 Degrees Fahrenheit
Location: Jackson dish machine
Violation Issued: No

Utensils surface temperatu: = at 160+ Degrees Fahrenheit
Location: Jackson dish machine
Violation Issued: No

Quaternary ammonium: = 400+ ppm at Degrees Fahrenheit
Location: Dispenser at 3 compartments sink
Violation Issued: No

Quaternary ammonium: = 0 ppm at Degrees Fahrenheit
Location: Wiping bucket
Violation Issued: Yes

Ambient air temperature: = at 37 Degrees Fahrenheit
Location: Walk in cooler
Violation Issued: No

Ambient air temperature: = at 8 Degrees Fahrenheit
Location: Walk in freezer
Violation Issued: No

Ambient air temperature: = at 6 Degrees Fahrenheit
Location: AdvantEdge double door freezer
Violation Issued: No

Ambient air temperature: = at 41 Degrees Fahrenheit
Location: Superior single door refrigerator
Violation Issued: No

Ambient air temperature: = at 39 Degrees Fahrenheit
Location: Beverage Air prep cooler
Violation Issued: No

Ambient air temperature: = at 48 Degrees Fahrenheit
Location: AdvantEdge reach in refrigerator-cook line
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Hot Hold/Tomato bisque
Temperature: 164 Degrees Fahrenheit - Location: Soup warmer
Violation Issued: No

Process/Item: Cold Hold/Cottage cheese
Temperature: 35 Degrees Fahrenheit - Location: Walk in cooler
Violation Issued: No

Type: Full
Date: 03/21/22
Time: 13:08:52
Report: 7958221059
The Legacy Of St Anthony

Food and Beverage Establishment Inspection Report

Page 3

Process/Item: Cold Hold/Cheese slices
Temperature: 36 Degrees Fahrenheit - Location: Walk in cooler
Violation Issued: No

Process/Item: Cold Hold/Roast beef
Temperature: 36 Degrees Fahrenheit - Location: Walk in cooler
Violation Issued: No

Process/Item: Cold Hold/Watermelon
Temperature: 36 Degrees Fahrenheit - Location: Walk in cooler
Violation Issued: No

Process/Item: Cold Hold/Lettuce
Temperature: 38 Degrees Fahrenheit - Location: Beverage Air prep cooler rails
Violation Issued: No

Process/Item: Cold Hold/Shredded cheese
Temperature: 38 Degrees Fahrenheit - Location: Beverage Air prep cooler rails
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 48 Degrees Fahrenheit - Location: AdvantEdge reach in refrigerator-cook line
Violation Issued: Yes

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

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT A FOOD SERVICE ESTABLISHMENT.

**IF ANY RESIDENT OR STAFF COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE DISH MACHINE WAS DETERMINED USING A MULTI-STRIP THERMAL LABEL TO BE AT LEAST 160 DEGREES F AS REQUIRED BY THE MINNESOTA FOOD CODE. AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

Type: Full
Date: 03/21/22
Time: 13:08:52
Report: 7958221059
The Legacy Of St Anthony

Food and Beverage Establishment Inspection Report

Page 4

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 7958221059 of 03/21/22.

Certified Food Protection Manager: Bradley Collins

Certification Number: FM4420 Expires: 05/13/22

Signed: _____

Bradley Collins
Executive Chef

Signed: _____

George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us