Electronically Delivered

June 2, 2023

Licensee
St. Andrew's Village
220 East Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL21177015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21177	A. BUILDING: _____ B. WING _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S VILLAGE	220 EAST AVENUE MAHTOMEDI, MN 55115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: SL21177015 On May 15, 2023, through May 19, 2023, 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 67 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control (IC) program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on February 13, 2020, with diagnosis including diabetes mellitus type 2 (DM II), congestive heart failure, obstructive sleep apnea, obesity, and atrial fibrillation. R5's Physician Orders signed February 2, 2023, indicated R5 had a right heel ulcer related to R5's DM II and obesity diagnoses. R5's Assessment As Of Date completed on May	0 510		

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0 510	Continued From page 3 2, 2023, indicated under Skin area, R5's left heel wound measured 1.0 x 1.1 x 0.1 centimeters (cm) and had an additional wound on the top of the left foot measuring 3 x 3.5 x 0.1 cm. R5's diagnosis of DM II and open wound placed R5 at an increased risk of contraction of an infection. On May 16, 2023, at approximately 7:00 a.m., the surveyor observed R5's private room. In R5's bathroom an over the toilet commode chair (also referred to as a raised toilet seat or commode) was in place. The commode had multiple layers of gray duct tape wrapped around the front center and slightly to right on the seated area. The duct tape appeared to have been in place for an extended period of time as evidenced by the edges of the tape appeared frayed, multiple layers in place, and some edges of the tape was peeled back. Many areas of the tape were stained brown and areas where the tape had peeled back exposing the adhesive side contained urine and fecal matter. On May 17, 2023, at approximately 9:15 a.m., clinical nurse supervisor (CNS)-D stated they were responsible for the development and implementation of licensee's IC program and R5's commode would be an IC concern for R5. CNS-D stated the licensee would need to complete an assessment related to the commode and put a cleaning routine in place to ensure IC procedures are maintained and implemented to prevent possible spread of an infection to R5 or staff who work in the area. The licensee's Infection Prevention and Control Manual dated 2020, indicated the licensee would develop an IC program which would include, "A system for preventing, identifying, reporting, investigating, and controlling infections and	0 510		

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0 510	Continued From page 4 communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 970 SS=C	144G.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 that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 970		

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0 970	Continued From page 5 The findings include: On May 15, 2023, at approximately 11:00 a.m., licensed assisted living director (LALD)-C provided licensee's current Residency Agreement with revised date October 1, 2022, and identified the document as licensee's assisted living contract. Page three (3) of the assisted living contract indicated by signing the assisted living contract, the resident acknowledges they received and reviewed the Resident Handbook. The licensee's Resident Handbook dated August 2021, on page 37 Wheelchairs/Walkers/Motorized Carts section read, "The community is not liable for damage or injury associated with the operation of the vehicle." On May 17, 2023, at approximately 12:00 p.m., LALD-E stated licensee would adjust the liability waiver language currently in the contract. LALD-E stated the corporate office would be notified of the liability waiver and address it. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 6 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 7 (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired March 8, 2021. On May 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C provided ULP-B's undated Relias (online training platform) Transcript and stated document would contain all orientation training ULP-B had completed.	01470		

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01470	Continued From page 8 ULP-B's orientation training record lacked evidence ULP-B had completed the following required orientation: - Overview of assisted living statutes; - A review of licensee's policies and procedures; - Handling emergencies; - Handling and reporting resident complaints; - Review of licensee's assisted living services and licensee's scope of license; and - Principles of person-centered planning and service delivery. On May 15, 2023, at 2:30 p.m., LALD-C stated ULP-B had failed to complete their required orientation trainings listed above. LALD-C stated they were unsure why ULP-B's required training was not completed. On May 16, 2023, at approximately 7:00 a.m. during continuous observations, the surveyor observed ULP-B provide medication administration, treatment administration, housekeeping, meal preparation, and delegated tasks to multiple residents. ULP-B stated they had worked for the licensee for over two (2) years and had provided similar services during that time. The licensee's Education and Training Policy with revised date April 2022, indicated licensee would provide onboarding, training, and continuous education to meet regulatory requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01500	Continued From page 9	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 10 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). 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:	01500		

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01500	Continued From page 11 RN-A RN-A was hired on January 31, 2022. On May 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C provided RN-A's undated Relias (online training platform) Transcript and stated document would contain all annual training RN-A had completed. RN-A's annual training record lacked evidence RN-A had completed the following required annual training: - Reporting maltreatment of vulnerable adults; - Assisted living bill of rights; - Review of infection control techniques; - Effective approaches to use to problem solve when working with a resident's challenging behaviors; and - Review of licensee's policies and procedures. On May 16, 2022, at 8:10 a.m., the surveyor observed RN-A assist with redirection of an agitated resident and provide delegation to unlicensed personnel. ULP-B ULP-B was hired March 8, 2021. On May 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C provided ULP-B's undated Relias Transcript and stated document would contain all annual training ULP-B had completed. ULP-B's annual training record lacked evidence ULP-B had completed the following required annual training: - Reporting maltreatment of vulnerable adults; - Assisted living bill of rights; - Review of licensee's policies and procedures;	01500		

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01500	Continued From page 12 and - Principles of person-centered planning and service delivery. On May 16, 2023, at approximately 7:00 a.m., during continuous observations, the surveyor observed ULP-B provide medication administration, treatment administration, housekeeping, meal preparation, and delegated tasks to multiple residents. ULP-B stated they had worked for the licensee for over two (2) years and had provided similar services during that time. On May 15, 2023, at 2:30 p.m., LALD-C stated ULP-B and RN-A had failed to complete their respected required annual trainings listed above. The licensee's Education and Training Policy with revised date April 2022, indicated licensee would provide onboarding, training, and continuous education to meet regulatory requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	01540		

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01540	Continued From page 13 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 observation, interview, and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date and failed to ensure the required two (2) hours of annual dementia care training for each 12 months of employment was completed for direct-care employees in the required time frame for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). 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 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: RN-A RN-A was hired on January 31, 2022, to provide direct care to the residents and supervise the	01540		

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01540	Continued From page 14 staff. On May 16, 2022, at 8:10 a.m., the surveyor observed RN-A assist with redirection of an agitated resident and provide delegation to unlicensed personnel. RN-A's employee record lacked documentation of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date. RN-A's employee record had four and a half (4.5) hours of documented initial dementia care training. In addition, RN-A's record lacked documentation of the required two (2) hours of annual dementia care training for each 12 months of employment. RN-A's employee record had .25 hours of documented annual dementia care training. ULP-B ULP-B was hired March 8, 2021. On May 16, 2023, at approximately 7:00 a.m., during continuous observations, the surveyor observed ULP-B provide medication administration, treatment administration, housekeeping, meal preparation, and delegated tasks to multiple residents. ULP-B stated they had worked for the licensee for over two (2) years and had provided similar services during that time. On May 15, 2023, at approximately 12:00 p.m., licensed assisted living director (LALD)-C provided ULP-B's undated Relias (online training platform) Transcript and stated document would contain all annual training ULP-B had completed. ULP-B's employee record lacked documentation	01540		

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01540	Continued From page 15 of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date and lacked documentation of the required two (2) hours of annual dementia care training for each 12 months of employment. On May 16, 2023, at 1:35 p.m., LALD- E stated RN-A and ULP-B were missing the full 8 required hours of initial dementia care training and the two required hours of annual dementia care training. The licensee's Dementia Training Policy dated August 1, 2021, indicated employees who have not completed their initial dementia care training will not provide direct care independently. Employees will receive training on topics related to dementia care for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 16 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse completed a comprehensive nursing assessment that included all required content for one of five residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on February 13, 2020, with diagnosis including diabetes mellitus type 2 (DM II), congestive heart failure, obstructive sleep apnea, obesity, muscle weakness, repeated falls, and atrial fibrillation. R5's Assessment As Of Date completed on May	01620		

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01620	Continued From page 17 2, 2023, read, "Mobility - Transfer Status Independent with transfer without adaptive equipment." On May 16, 2023, at approximately 7:00 a.m., the surveyor observed R5 transfer from their electric wheelchair to a recliner in R5's private room. R5 required the use of a walker to support and stabilize themselves in order to safely and effectively transfer self from the electric wheelchair to the recliner. On May 16, 2023, at approximately 7:00 a.m., the surveyor observed R5's private room. In R5's bathroom an over the toilet commode chair (also referred to as a raised toilet seat or commode) was in place. On May 16, 2023, at approximately 7:00 a.m., unlicensed personnel (ULP)-B stated R5 used the commode to self-transfer from their electric wheelchair to the toilet and back. ULP-B stated R5 would not be able to get themselves on the toilet if the commode was not in place. On May 17, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-D stated the commode and walker would need to be assessed and indicated as safe for R5 to use on R5's comprehensive assessment. CNS-D stated all assistive devices should have been included on R5's assessments. Per the Minnesota Administrative Rules 4659.0150 Uniform Assessment Tool Subp. 2. (B) (3) assistive devices are required to be assessed. The licensee's MN AL Nursing Assessment Policy dated May 3, 2022, indicated assistive devices would be included in the licensee's assessments.	01620		

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01620	Continued From page 18 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
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. (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 the current service plan included a signature or other authentication by the licensee or resident or resident's representative to document agreement of services to be provided for two of five residents	01640		

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01640	Continued From page 19 (R4, R6). 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: R4 R4 was admitted on July 19, 2021. R4's Service Plan -Attachment E to Residency Agreement with effective date of September 8, 2022, was provided by licensed assisted living director (LALD)-C who indicated it was R4's most currently authenticated and agreed upon service plan. R4's Service Plan -Attachment E to Residency Agreement with effective date of May 16, 2023, had an increase in the Total Monthly Charges, and lacked authentication by the licensee or resident or resident's representative to document agreement of the services to be provided. R6 R6 was admitted on August 26, 2022. R6's Service Plan -Attachment E to Residency Agreement with effective date of August 26, 2022, was provided by LALD-C who indicated it was R6's most currently authenticated and agreed upon service plan.	01640		

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01640	Continued From page 20 R6's Service Plan -Attachment E to Residency Agreement with effective date of May 16, 2023, had an increase in the Total Monthly Charges, and lacked authentication by the licensee or resident or resident's representative to document agreement of the services to be provided. On May 16, 2023, at 2:05 p.m., LALD-E stated the service agreement price discrepancy is due to an increase in rent and service charges and a notification in pricing changes was sent out to residents and families by email, but they were not required to sign anything. The licensee's MN AL Service Plan policy dated August 1, 2021, indicated service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of five residents	01880		

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01880	Continued From page 21 (R5) reviewed with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on February 13, 2020, with diagnosis including diabetes mellitus type 2 (DM II), congestive heart failure, obstructive sleep apnea, obesity, and atrial fibrillation. R5's Assessment As Of Date completed on May 2, 2023, indicated under Medications section R5's medications require secure storage including a lockbox in R5's refrigerator for insulin. R5's Service Plan - Attachment E to Resident Agreement with effective date of May 16, 2023, indicated R5 received the service of Medication Administration and read the licensee, "requires a prescriber's order for all medications managed or administered by our staff, including over-the-counter medications. Medication will be kept in the apartment in a locked box or cabinet." On May 16, 2023, at approximately 7:00 a.m., the surveyor observed R5's private room with unsecured medications including, acetaminophen (pain reliever), nitroglycerin (emergency use for heart attack), Pepto-Bismol (treat common stomach symptoms), MiraLAX (helps with	01880		

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01880	Continued From page 22 constipation), ducolax (helps with constipation), docusate sodium (stool softener), milk of magnesium (helps with constipation), and Eucerin cream (use for dry skin). On May 16, 2023, at approximately 7:00 a.m., unlicensed personal (ULP)-B provided medication administration to R5. ULP-B obtained R5's medications from a locked cabinet located above R5's kitchen counter. ULP-B administered R5's medication per the medication administration record. ULP-B stated R5 will occasionally self-administer the unsecured medications when R5 feels they need them. On May 17, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-D stated all medications in R5's room should be secured. CNS-D stated R5 will procure medications that should be managed by the licensee and those medications would be unsecured in R5's room. The licensee's AL Medication Management Policy dated March 6, 2023, read, "all medications will be stored in a locked box in a cabinet." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01890		

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01890	Continued From page 23 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of five residents (R8). 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 May 16, 2023, at 9:00 a.m., the surveyor observed R8's medication cabinet and observed the following expired medications: - lorazepam 0.5 milligram (mg) with an expiration date of April 2, 2023; - haloperidol 0.5 mg with an expiration date of March 5, 2023; and - hydromorphone 1 mg with an expiration date of March 30, 2023. On May 16, 2023, at 9:15 a.m., registered nurse (RN)-A stated the medications are past the discard date and she had been looking at the refill date and not the discard date when monitoring for expired medications. The licensee's MN AL Medication Destruction Policy dated February 16, 2023, indicated pharmaceutical waste includes any medication remaining after discontinuation, expiration,	01890		

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01890	Continued From page 24 discharge, or death of resident that is not able to be returned to the dispensing pharmacy for credit and re-use. Determination of method of destruction of pharmaceutical waste will be evaluated at the time of resident discharge, discontinuation or expiration of medication, or resident death. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01950		

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01950	Continued From page 25 review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5) who had an ordered treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on February 13, 2020, with diagnosis including diabetes mellitus type 2 (DM II), congestive heart failure, obstructive sleep apnea, obesity, and atrial fibrillation. R5's Service Plan - Attachment E with effective date of April 12, 2023, indicated R5's received the service of, "NO CHARGE Ted (Thrombo-Embolic Deterrent or commonly referred to as compression stockings) Assist/Ace Wraps inc. w/AM or PM car." R5's Assessment As Of Date completed on May 2, 2023, read under ADL (activities of daily living) Needs, "staff assistance with putting on and taking off sot stockings and Velcro wraps BLE," (both lower extremities). The assessment also indicated under Skin area, R5's left heel wound measured 1.0 x 1.1 x 0.1 centimeters (cm) and had an additional wound on the top of the left foot measuring 3 x 3.5 x 0.1 cm.	01950		

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ST ANDREW'S VILLAGE	220 EAST AVENUE MAHTOMEDI, MN 55115

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01950	Continued From page 26 On May 16, 2023, at approximately 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-B apply a foam dressing to a wound on R5's left heel and then apply R5's TED hose. R5's Daily Assignments dated May 16, 2023, at 11:58 a.m., read, "NO CHARGE Ted Assist/Ace Wraps inc. w/AM or PM car. Dressing on left heel, needs Teds on and Black Velcro wraps to both legs HAS a foam heel protector for left heel." R5's treatment management record lacked specific instructions for R5 when an ULP would not apply R5's TED hose and contact the nurse or licensed health professional. On May 17, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-D stated instructions or indications for when a ULP should not apply R5's TED hose were not included by a registered nurse's assessment in R5's treatment record. CNS-D stated instructions would need to be included related to R5's wound on their heel and when TED hose should not be applied by the ULP, and the licensee's nurse would be notified. The licensee's MN AL Treatment and Therapy Management Policy dated March 7, 2023, indicated resident specific instructions would be included in each resident's respected treatment management record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21177	A. BUILDING: _____ B. WING _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S VILLAGE	220 EAST AVENUE MAHTOMEDI, MN 55115

(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
02070	Continued From page 27	02070		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an awake person was physically present in a secured care unit, 24 hours a day, seven days a week who was responsible for responding to requests of residents for assistance in a secured area. This had the potential to affect all residents in the secured dementia care unit. 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: R7 was admitted on February 10, 2020, and resided in the unsecured area of the facility. R7's Resident Notes dated May 6, 2023, at 12:10 a.m. read, "[Unlicensed Personnel (ULP)] states,	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21177	A. BUILDING: _____ B. WING _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S VILLAGE	220 EAST AVENUE MAHTOMEDI, MN 55115

(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
02070	Continued From page 28 [R7] tripped over [their] comforter, denies hitting [their] head, no c/o pain at the time of fall, RN [registered nurse] instructed to follow fall protocol and assist res up with the mech lift." On May 16, 2023, at 11:30 a.m., licensed assisted living director (LALD)-E provided R7's Resident Occurrence Report for an occurrence on May 5, 2023, at 12:00 a.m. The report indicated R7 tripped on R7's bed spread and was found on the floor between R7's bed and chair. R7's AL Falls Follow Up Form signed on May 9, 2023, at 4:00 p.m., read, "Short Term Intervention: Assisted off the floor by staff with mechanical lift." The licensee's daily schedule provided by LALD-E dated Saturday May 6, 2023, indicated two (2) staff members were working on the NOC (commonly used term for the overnight) shift. One staff was assigned to the secured unit, and one assigned to the unsecured unit. On May 15, 2023, at 10:00 a.m., during the entrance conference, LALD-C and clinical nurse supervisor (CNS)-C stated when residents sustain a fall, licensee's protocol is to use two (2) staff members to assist the person off the floor with the aid of a mechanical lift. On May 17, 2023, at 8:00 a.m., LALD-E stated ULP working in the secured unit had left the secured unit leaving no staff in the secured unit. ULP from the secured unit assisted the other staff in the unsecured unit with use of mechanical lift to assist R7 off the floor. LALD-E stated licensee is aware a staff member must be in the secured unit at all times. LALD-E stated the ULP was instructed by the on-call RN to assist the other	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21177	A. BUILDING: _____ B. WING _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREW'S VILLAGE	220 EAST AVENUE MAHTOMEDI, MN 55115

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02070	Continued From page 29 staff, and left the secured unit as instructed. CNS-C stated the on-call RN must have not realized instructing the ULP to leave the secured unit would leave the secured with no staff. CNS-D stated the nurses are aware the secured units must always have a staff member present. The licensee's MN AL Direct Care Staffing Plan Policy dated August 12, 2021, indicated a staff member must be present in the building, but the policy did not identify a staff member must always be present in the secured unit. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		

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

Type: Full
Date: *05/15/23*
Time: 13:27:16
Report: 8058231116

Food and Beverage Establishment Inspection Report

Location:
St Andrew's Village
240 East Avenue
Mahtomedi, MN55115
Washington County, 82

Establishment Info:
ID #: 0038219
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517624100
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.

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
CURRENTLY AWAITING CFPM CERTIFICATE
Comply By: 06/30/23

5-200A Plumbing: approved materials/design
5-201.11B
MN Rule 4626.1040B Maintain the plumbing system in good repair.
HANDWASHING SINK LEAKING FROM TRAP
Comply By: 05/26/23

Surface and Equipment Sanitizers

Acid: = 700 at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Hot Water: = --- at 176 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

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

Food and Beverage Establishment Inspection Report

Process/Item: SHRIMP
Temperature: 38 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

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

Process/Item: POTATO
Temperature: 160 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Process/Item: PORK
Temperature: 155 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Process/Item: HAM
Temperature: 40 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

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

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

HRD INSPECTION

COMMERCIAL FACILITY

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 8058231116 of 05/15/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
MICHELLE CRESCENZO
PIC

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