Electronically Delivered

March 13, 2025

Licensee
Woodbury Villa
7008 Lake Road
Woodbury, MN 55125

RE: Project Number(s) SL30223016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30223	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY VILLA	7008 LAKE ROAD WOODBURY, MN 55125

(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: SL #30223016-0 On February 10, 2025, through February 12, 2025, 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 71 residents, 67 of whom were receiving services under the provider's Assisted Living Facility 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 3	0 510		
0 510 SS=F	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 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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene for two of two staff (unlicensed personnel (ULP)-D, ULP-E). The licensee further failed to ensure proper infection control technique was followed for needle injection of medication by one of two staff (ULP-D). 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).	0 510		

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0 510	Continued From page 4 The findings include: ULP-D and ULP-E were hired May 26, 2023, and June 26, 2023, respectively, and provided direct care services for residents. HAND HYGIENE ULP-D On February 11, 2025, during a continuous observation from 7:15 a.m. to 8:16 a.m., the surveyor observed ULP-D assist residents on the second floor with treatments, medication administration, and cares. -at 7:15 a.m., ULP-D entered R8's apartment. Without performing hand hygiene (HH), ULP-D donned clean gloves, used a lancet (a device to pierce the skin) to obtained drop of blood and checked R8's blood sugar. Using a piece of tissue paper, ULP-D removed the soiled blood glucose test strip and placed it into the trash can. ULP-D walked to the kitchen, removed the soiled gloves, and without performing HH, donned clean gloves. ULP-D prepared and administrated oral medications to R8. ULP-D removed the soiled gloves and without performing HH, left R8's room. -at 7:34 a.m., ULP-D entered R7's apartment. Without performing HH, ULP-D donned clean gloves. ULP-D retrieved a new adult pull-up brief from the closet, assisted R7 to sitting position to the edge of R7's bed, and placed the new pull-up brief halfway up R7's mid thighs. ULP-D assisted R7 to walk to the bathroom. ULP-D removed the soiled adult tabbed brief and placed it in the trash can. ULP-D handed R7 a packet of cleansing wipes and R7 independently wiped the perineum area. ULP-D removed the soiled gloves, and without performing HH, donned clean gloves. ULP-D returned to R7's bedroom, removed the soiled under pads from the bed, placed clean under pads onto the bed, placed new sheets onto	0 510		

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0 510	Continued From page 5 the bed, and placed R7's blanket over the mattress. ULP-D removed the soiled gloves, and without performing HH, left R7's apartment. -at 7:47 a.m., ULP-D entered R10's apartment. Without performing HH, ULP-D entered the kitchen area, retrieved a medication cup from their waist carry bag and placed it onto the kitchen counter. ULP-D prepared medications and handed the medication cup to R10. Without performing HH, ULP-D left R10's apartment. -at 7:52 a.m., ULP-D entered R6's apartment. Without performing HH, ULP-D prepared medications by placing medications into a medication cup and poured a liquid medication into a separate medication cup. ULP-D walked into R6's bedroom area, and administrated the medications to R6. Without performing HH, ULP-D left R6's apartment. -at 8:03 a.m., ULP-D entered R5's apartment. Without performing HH, ULP-D used a blood pressure cuff on R5's right wrist and recorded the reading. ULP-D walked to the kitchen, and prepared oral medications for R5. Without performing HH, ULP-D donned clean gloves, retrieved an insulin injection pen from the refrigerator. ULP-D administered oral medications to R5 and injected medication to R5's upper arm, using the injector pen. ULP-D placed the used needle into the sharps container, and returned the insulin pen to the refrigerator. ULP-D removed the soiled gloves, and documented the medications as administered. Without performing HH, ULP-D left R5's apartment. -at 8:16 a.m., ULP-D returned to R7's apartment. Without performing HH, ULP-D donned clean gloves. ULP-D applied a cream to R7's perineum area, and assisted with placing a large incontinence pad into the pull up brief. R7 walked independently back into their bedroom. ULP-D removed the soiled gloves. Without performing	0 510		

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0 510	Continued From page 6 HH, ULP-D donned clean gloves and administered eye drops to R7. ULP-D walked back to R7's bathroom, removed the trash bag and placed it outside R7's apartment. ULP-D removed the soiled gloves and placed them into a trash can. Without performing HH, R7 prepared and administered oral medications to R7. Without performing HH, ULP-D left the apartment. ULP-E On February 11, 2025, during a continuous observation from 7:15 a.m. to 8:05 a.m., the second surveyor observed ULP-E assisting residents with medication administration on the 3rd floor. -at 7:15 a.m., ULP-E entered R2's apartment. Without performing HH, ULP-E retrieved R2's morning medications from a locked cabinet in the kitchen, punched out the medications into a paper medication cup, obtained a glass of water for R2, and brought R2 the water and medications. ULP-E documented giving the medication and returned them to the cabinet. Without performing HH, ULP-E left R2's room. -at 7:30 a.m., ULP-E entered R3's apartment. Without performing HH, ULP-E retrieved R3's morning medications from a locked cabinet in the kitchen, punched out the medications into a paper medication cup, obtained a glass of water, and brought the water and medications to R3. ULP-E documented giving the medication and returned them to the cabinet. Without performing HH, ULP-E left R3's room. -at 7:45 a.m., ULP-E stated they had been trained by the registered nurse (RN) on infection control which included HH. -at 8:00 a.m., ULP-E entered R11's apartment. Without performing HH, ULP-E obtained R11's morning medications from a locked cabinet in the kitchen, punched out the medications into a paper	0 510		

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0 510	Continued From page 7 medication cup and brought the medications to R11. ULP-E documented giving the medication and returned them to the cabinet. Without performing HH, ULP-E left R11's room. -at 8:05 a.m., ULP-E entered R4's apartment. Without performing HH, ULP-E obtained R4's morning medications from a locked cabinet in the kitchen, punched out the medications into a paper medication cup and brought the medications to R4. ULP-E documented giving the medication and returned them to the cabinet. Without performing HH, ULP-E left R4's room. NEEDLE INJECTION INFECTION CONTROL R5's diagnoses included fracture of the 2nd cervical vertebra (break in the upper back), heart failure, hypertension (high blood pressure), muscle weakness, age related osteoporosis (weakening bones), epidural hemorrhage (collection of blood between the skull and the brain), fracture of the thoracic spine (break in the mid back), bruising to the lower back and pelvic area, hyperlipidemia (high cholesterol), abnormalities of gait (movement) and mobility, acute posthemorrhagic anemia (low blood volume), fracture of the neck, history of falling, and hearing loss. R5's Service Addendum to the Assisted Living Contract, dated February 4, 2025, indicated R5 received services including assistance with monthly vital signs, medication administration, and safety checks. R5's Medication Administration Record (MAR) indicated R5 received a Forteo injection 600/2.4 milliliter (ml), inject 0.08 ml once daily (used to increase bone strength and prevent bone fractures).	0 510		

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0 510	Continued From page 8 On February 11, 2025, at 8:03 a.m., the surveyor observed ULP-D assist R5 with medication administration. ULP-D opened the unlocked refrigerator in R5's apartment, removed the Forteo injection pen, and primed the injection pen. ULP-D approached R5, and, without first cleansing the injection site, injected the medication into R5's upper arm. On February 11, 2025, at 9:45 a.m., ULP-D stated they were trained to wash hands before donning and after removing gloves. ULP-D stated they forgot to perform HH during medication administration and cares as they were nervous. On February 11, 2025, at 9:51 a.m., ULP-D stated they were trained to look at the eMAR prior to administering medications. ULP-D did not answer why the eMAR was not viewed prior to administrating the medication. On February 11, 2025, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated staff were trained to wash before and after entering resident apartments. CNS-A stated staff were trained to change gloves and perform HH between each resident. CNS-A stated this situation should not have occurred and she was unsure why staff were not washing their hands. On February 11, 2025, at 12:54 p.m., CNS-A stated staff were trained to wipe down the skin prior to injection medication. CNS-A stated that situation should not have occurred and was unsure why that happened. The Center for Disease Control (CDC) Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended performing hand hygiene before and after providing cares and to	0 510		

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0 510	Continued From page 9 perform hand hygiene after glove removal. The Kaiser Foundation Drug Encyclopedia for Forteo subcutaneous pen injector, dated 2025, recommended the injection site be cleaned with rubbing alcohol prior to injecting the medication. The licensee's Hand Hygiene (Based on the CDC Guideline Hand Hygiene in Healthcare Settings) policy, revised July 2021, indicated proper hand washing techniques should be used to protect the spread of infection, and staff should sanitize their hands immediately after touching a resident or the resident's immediate environment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and	0 800		

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0 800	Continued From page 10 well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 February 12, 2025, from approximately 11:29 a.m. to 1:40 p.m., the surveyor toured the facility with environmental director (ED)-G. The exit ramp in the Southwest corner of the facility was cracked and damaged with sections that have fallen loose. Area should be maintained in proper condition free of cracks or holes that may contribute to tripping hazard. The exit ramp in the Southeast corner of the facility had loose, cracked and missing bricks. Area should be maintained in proper condition without deterioration, cracks or damage that way degrade integrity of ramp. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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:	0 810		

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	30223	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY VILLA	7008 LAKE ROAD WOODBURY, MN 55125

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0 810	Continued From page 11 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required resident training and evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 12 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 12, 2025, at approximately 1:10 p.m., environmental director (ED)-G provided documentation on the fire safety and evacuation plan (FSEP), fire safety, and evacuation training. The licensee's FSEP failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP did not include any documentation of training provided to residents on fire safety or evacuation procedures. Trainings must be offered to residents capable of assisting in their own evacuation at least once annually. The FSEP did not include documentation of training on FSEP provide to employees. ED-G stated that the facility was working on developing these trainings and documents after becoming aware of their requirements on a recent survey at another facility where they were made aware of the requirements. The FSEP failed to include information on required fire drills for employees.	0 810		

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0 810	Continued From page 13 During interview on February 12, 2025, the surveyor explained the requirements for frequency of drills, resident training, employee training, and documentation. ED-G stated they understood the requirements and had recently begun working on developing the required documents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing comprehensive reassessments using the uniform assessment tool at an interval not to exceed 90 days for four of four residents (R2, R3, R6, R7). 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: R2 R2's service plan, dated August 20, 2024, indicated R2 received services to include assistance with medication administration. R2's record included a comprehensive nursing assessment, dated April 5, 2024, and a subsequent assessment completed October 15, 2024 (193 days after the previous assessment). R3 R3's service plan, dated October 21, 2024, indicated R3 received services to include assistance with medication administration. R3's record included a comprehensive nursing assessment dated August 12, 2024, and a subsequent assessment completed December 12, 2024 (122 days after the previous	01620		

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01620	Continued From page 15 assessment). R6 R6's service plan, dated January 7, 2025, indicated R6 received services to include assistance with medication administration, vital signs, medical monitoring, safety checks, and toileting. R6's record included a comprehensive nursing assessment, dated October 30, 2024, and a subsequent assessment completed February 4, 2025 (97 days after the previous assessment). R7 R7's service plan, dated January 17, 2025, indicated R7 received services to include assistance with bathing, placement of compression stockings, toileting, incontinence assistance, monthly vital signs, medication administration, laundry, bed making, in room dining, trash removal safety check, dressing, and transfer assistance with one person. R7's record included a comprehensive nursing assessment, dated September 23, 2024, and a subsequent assessment completed January 17, 2025 (116 days after the previous assessment). On February 11, 2025, at 12:56 p.m., clinical nurse supervisor (CNS)-A stated they were responsible for the assessments for the residents. CNS-A stated assessments should be completed every 90 days or with a change of condition. CNS-A stated it was an oversight and the assisted living facility can be busy for one registered nurse. The licensee Comprehensive Assessment Schedule, revised August 2022, indicated	01620		

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01620	Continued From page 16 "ongoing client monitoring and reassessment," would be conducted by the registered nurse at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to appropriately dispose of discontinued medications for one of four residents (R4).	01910		

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01910	Continued From page 17 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: R4's service plan, dated December 17, 2024, indicated R4 received services to include assistance with medication administration. R4's record included a provider's order, dated October 7, 2024, for ofloxacin 0.3% ear drops (used to treat ear infection), apply 3-5 drops to the left ear canal twice daily for 7 days. On February 4, 2025, at 12:40 p.m., during an observation of R4's medication storage basket with licensed practical nurse (LPN)-F, a box containing ofloxacin 0.3% ear drops was observed. LPN-F stated the ear drops were discontinued and should have been removed. LPN-F removed the medication from the basket and stated she would destroy it. On February 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated discontinued medications should have been removed from the resident's room and she was not sure why it was missed. The licensee's Medication and Treatments policy, revised March 2021, indicated medications that had been discontinued would be destroyed.	01910		

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01910	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation and interview, and record reivew, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for three of nine residents (R6, R7, R10). 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: R7 R7's diagnoses included spinal stenosis	02320		

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02320	Continued From page 19 (narrowing of the spinal canal), fusion of the spine (parts of the spine surgically attached), spondylosis with myelopathy cervical region (degeneration of the bonds in the vertebrae), personal history of urinary tract infections, retention of urine (inability to urinate), chronic pain, muscle weakness, history of COVID-19, carpal tunnel syndrome (compressed nerve in the wrist), atrial fibrillation (irregular heart beat), vitamin D deficiency, and neuralgia and neuritis (generalized nerve pain). R7's service plan, dated January 17, 2025, indicated R7 received services including assistance with bathing, toileting, incontinence cares, monthly vital signs, medication administration, and transfer assistance with one person. On February 11, 2025, at 8:26 a.m., the surveyor observed ULP-D assist R7 with medication administration. ULP-D entered R7's bedroom, and without referencing the Medication Administration Record (MAR) to verify the medication dosage, administered ketotifen solution eye drops to R7. ULP-D then opened the electronic medical record (eMAR), documented the ketotifen eye drops as administered, then prepared R7's oral medications. R7's MAR dated January 1, 2025, through January 31, 2025, indicated R7 received ketotifen solution eye drops (used to treat itching of the eyes) 0.035 percent (%) instill one drop in each eye. On February 11, 2025, at 9:51 a.m., ULP-D stated they were trained to look at the eMAR prior to administering medications. ULP-D did not address why they did not look at the eMAR prior	02320		

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02320	Continued From page 20 to administrating the eye drops. On February 11, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-A stated staff were trained to look at the electronic medical record prior to administering all medications. CNS-A stated ULP-D should have verified the medications prior to administering them to R7. CNS-A stated ULP-D probably did not verify the eye drop medication as R7 received that medication every day. The licensee's Medications and Treatments policy, dated March 2021, indicated staff would follow the "6 rights" of medication administration: right person, right medication, right time, right route (i.e. by mouth, eye drops, to the skin), right dose (i.e. how many milligrams, drops), right chart/record to document that the medication was taken. R6 R6's diagnoses included fracture of the sixth cervical vertebra (broken back), severe protein-calorie malnutrition, anxiety disorder, hypertension (high blood pressure), bacterial peritonitis (infection of the lining of the abdominal cavity, amenia (low iron count), hypothyroidism (under active thyroid gland), major depressive disorder, chronic atrial fibrillation (irregular heart beat), nontraumatic subarachnoid hemorrhage (brain bleed), alcoholic cirrhosis of the liver (hardening of the liver), hepatic failure (liver failure), chronic kidney disease, and alcohol dependence in remission, R6's service plan, dated January 7, 2025, indicated R6 received services including assistance with medication administration.	02320		

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02320	Continued From page 21 On February 11, 2025, at 7:53 a.m., the surveyor observed ULP-D assisting R6 with medication administration. ULP-D poured lactulose liquid medication into a medication cup approximately one-half full. There were no graduation marks on the medication cup to indicate how much lactulose liquid was in the medication cup. ULP-D walked from the kitchen area into R6's common area and handed the liquid medication to R6. In the interest of safety, the surveyor stopped the medication administration. R6's medication administration record (MAR) dated January 1, 2025, through January 25, 2025 indicated R6 received the following medication: lactulose solution (used to treat constipation) 10gm/15 milliliters (ml) three times daily. On February 11, 2025, at 7:55 a.m., ULP-D stated they were trained to measure the exact amount using graduation marks on the medication cup. ULP-D stated they did not know if they poured the correct amount of medication for R6. ULP-D pointed to the halfway point on the medication cup and stated there was no graduation line to determine the correct amount to be administered. On February 11, 2025, at 12:43 p.m., CNS-A stated staff were trained to follow the MAR. CNS-A stated staff were trained to measure the required amount of medication using a graduated measuring cup. CNS-A stated that situation should not have occurred. CNS-A stated they were unsure why this happened, and ULP-D should have contacted the registered nurse (RN) for further direction. R10 R10's diagnoses included hypertension (high	02320		

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02320	Continued From page 22 blood pressure), generalized anxiety disorder, dorsalgia (back pain), calculus of gallbladder (hardening of the gallbladder), hydronephrosis (unwanted fluid in the kidneys), calculus of the kidney and ureter, tremors, intraductal carcinoma in situ of the unspecified breast (breast cancer), noninfective gastroenteritis and colitis (inflammation of the digestion tract), cardiac placement (a device that regulars the heartbeat), atrial fibrillation (irregular heartbeat), urinary incontinence (inability to control urine), and tachy brady syndrome (irregular heat rate). R10's service plan, dated January 24, 2025, indicated R10 received services including assistance with laundry, medication administration, monthly vital signs, and ace wraps. On February 11, 2025, at 7:47 a.m., in R10's apartment, ULP-D was observed placing the following medications into a medication cup: aspirin 81 mg 1 tablet, 2 gabapentin 600 tablets, 1 metoprolol 100 mg tablet, and 1 omeprazole 20 mg tablet. ULP-D handed the medication cup to R10 who was standing in the kitchen. Without watching R10 take the medications, ULP-D walked out of the apartment. R10's MAR dated January 1, 2025, through January 31, 2025, indicated R10 received the following medications: aspirin 81 mg 1 tablet once daily, gabapentin 600 mg 2 tablets twice daily, metoprolol 100 mg 1 tablet twice daily, omeprazole 20 mg 1 tablet once daily, topiramate 50 mg 1 tablet twice daily, vitamin B complex/vitamin C 1 tablet once daily, digoxin 0.125 1 tablet once daily, diclofenac gel 1 percent (%), loperamide 2 mg 1 capsule as needed and, Metamucil 1 packet into liquid.	02320		

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02320	Continued From page 23 R10's Assessment, dated February 12, 2025, included the Medication and Treatment Evaluation and Management Plan which indicated the licensee would store all medications in a locked cabinet and staff would administer medications. On February 11, 2025, at 9:45 a.m., ULP-D stated they were trained to watch all residents take their medications. ULP-D stated there were no instructions to leave the medications with R10. ULP-D stated R10 had been requesting staff not observe them take the medications. On February 11, 2025, at 12:46 p.m., CNS-A stated staff were trained to observe residents take their medications and not to leave medications with residents. CNS-A stated there was never a reason to leave medications with residents. CNS-A stated that situation should not have happened and was unsure why that happened. The licensee's Medications and Treatments policy, dated March 2021, indicated staff would follow the "6 rights" of medication administration: right person, right medication, right time, right route (i.e. by mouth, eye drops, to the skin), right dose (i.e. how many milligrams, drops), right chart/record to document that the medication was taken. The guideline lacked a statment indicating staff would ensure the resident had taken the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

DEPARTMENT OF HEALTH

Type: Follow-Up
Date: *02/19/25*
Time: 14:33:00
Report: 1036251031

Food and Beverage Establishment Inspection Report

Location:
Woodbury Villa
7008 Lake Road
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0038598
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515012101
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 164 Degrees Fahrenheit
Location: KITCHEN DISH MACHINE
Violation Issued: No

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

THIS FOLLOW-UP INSPECTION WAS COMPLETED BY JEFF JOHANSON (MDH) ALONG WITH CFPM CHRISTINE HASTINGS. SINCE THE FULL OPERATIONAL INSPECTION CONDUCTED ON 2/10/25, 4 OF 4 ORDERS HAVE BEEN CLEARED FROM THE REPORT.

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

I acknowledge receipt of the inspection report number 1036251031 of 02/19/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____ Signed:_____

CHRISTINE HASTINGS
PERSON IN CHARG

Jeff Johanson

DEPARTMENT OF HEALTH

Type: Full
Date: *02/10/25*
Time: 14:15:18
Report: 1036251027

Food and Beverage Establishment Inspection Report

Location:
Woodbury Villa
7008 Lake Road
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0038598
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515012101
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THE DISH MACHINE WAS NOT ABLE TO REACH THE REQUIRED 160 DEGREE F UTENSIL SURFACE TEMPERATURE FOR PROPER SANITIZING AFTER SEVERAL RUNS. ADVISED TO UTILIZE 3 COMP SINK FOR ALL WAREWASHING UNTIL UNIT CAN BE SERVICED.

Comply By: 02/13/25

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

THE CAULK SEALANT SECURING THE HANDWASHING SINK TO THE WALL IS DETERIORATING. REPAIR AND MAINTAIN.

Comply By: 03/03/25

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.

OBSERVED A BROKEN BUTTON ON THE MICROWAVE. REPAIR AND MAINTAIN.

Comply By: 03/03/25

Type: Full
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6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

OBSERVED SOME DAMAGED CEILING TILES IN THE ENTRANCE OF THE KITCHEN. REPLACE AND MAINTAIN.

Comply By: 03/03/25

Surface and Equipment Sanitizers

QUATERNARY AMMONIA: = 300PPM at Degrees Fahrenheit
Location: 3 COMP SINK SANITIZER DISPENSER
Violation Issued: No

UTENSIL SURFACE TEMP: = at 155 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: 3 DOOR TRAULSEN REACH IN COOLER
Violation Issued: No

Process/Item: Cooling/CHX DUMPLING
Temperature: 93 Degrees Fahrenheit - Location: 3 DOOR TRAULSEN REACH IN COOLER (AFTER 1 HR)
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -10 Degrees Fahrenheit - Location: MCCALL 3 DOOR FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS TAMMY CARLSON INSPECTION CONDUCTED IN PRESENCE OF CHRISTINE HASTINGS, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- COOLING/REHEATING PROCEDURES.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.

Food and Beverage Establishment Inspection Report

**IF ANY RESIDENT COMPLAINS 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.

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

I acknowledge receipt of the inspection report number 1036251027 of 02/10/25.

Certified Food Protection Manager: CHRISTINE M. HASTINGS

Certification Number: 41603 Expires: 04/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHRISTINE HASTINGS
PERSON IN CHARGE

Signed: _____
Jeff Johanson