



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2025

Licensee

The Legacy Of St. Michael
4400 Lange Avenue North
Saint Michael, MN 55376

RE: Project Number(s) SL29185016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. 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>

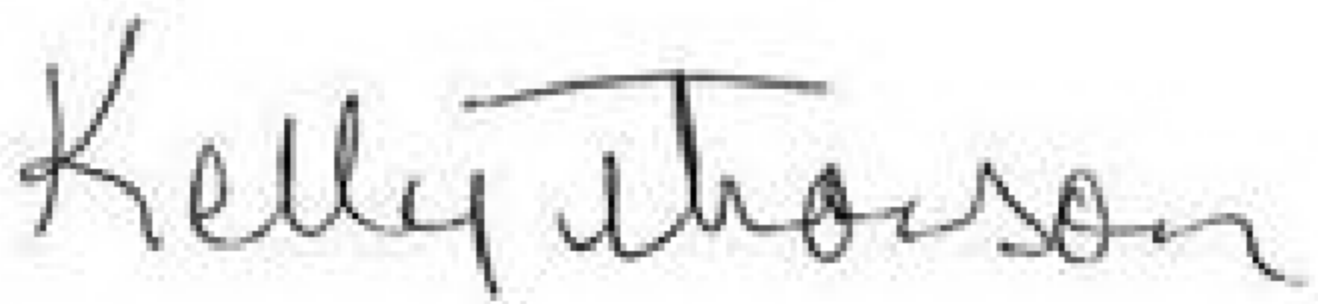
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29185	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2025
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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST MICHAEL	STREET ADDRESS, CITY, STATE, ZIP CODE 4400 LANGE AVENUE NE SAINT MICHAEL, MN 55376
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(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	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL29185016-0</p> <p>On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 92 resident(s); 73 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 480	<p>Continued From page 1</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are</p>	0 480		

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0 480	<p>Continued From page 2</p> <p>allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		

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0 510 SS=F	<p>144G.41 Subd. 3 Infection control program</p> <p>(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.</p> <p>(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.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control by two of three employees (unlicensed personnel (ULP)-B and ULP-H).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B ULP-B began providing cares to the residents on</p>	0 510		
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0 510	<p>Continued From page 4</p> <p>November 29, 2023.</p> <p>On February 25, 2025, from 8:08 a.m., through 8:30 a.m., during continuous observation surveyor observed ULP-B provide morning cares to R6. ULP-B washed hands and donned gloves, then helped R6 get shoes on. ULP-B then removed gloves and without performing hand hygiene donned new gloves and assisted R6 to the bathroom. ULP-B removed a urine-soaked brief from R6 and then removed soiled gloves. Without performing hand hygiene ULP-B donned new gloves and gathered clean clothes for R6. ULP-B then assisted R6 with putting on a clean brief and getting dressed. ULP-B removed gloves and without performing hand hygiene donned new gloves. ULP-B then removed R6's soiled shirt and washed R6's face, neck, under arms and then placed a clean t-shirt on R6 and applied lotion to his arms then helped him into a flannel shirt and assisted him with putting on his glasses. ULP-B then provided peri care to R6 and pulled up R6's brief and pants, then transferred R6 to the sink and assisted R6 with oral cares. ULP-B wiped his face then combed his hair and then assisted him to his recliner. ULP-B removed gloves and washed hands.</p> <p>On February 25, 2025, at 8:46 a.m., ULP-B stated, "We wash our hands when we come and when we leave the room and in between cares we just change our gloves like when I changed his shoes, I just change my gloves."</p> <p>ULP-H ULP-H began providing cares to the residents on January 23, 2025.</p> <p>On February 25, 2025, from 8:51 a.m., through 9:03 a.m., during continuous observation surveyor</p>	0 510		

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0 510	<p>Continued From page 5</p> <p>observed ULP-H donned gloves and gathered supplies for R4. ULP-B administered one eye drop to R4 and then removed gloves. Without performing hand hygiene ULP-B donned new gloves and administered R4's oral medications. ULP-H removed gloves and without performing hand hygiene donned new gloves and administered another eye drop to R4. ULP-H removed gloves and failed to perform hand hygiene.</p> <p>On February 25, 2025, at 9:08 a.m., ULP-H stated, "You need to wash your hands if you help the resident in the bathroom or if you got visibly soiled and we can use hand sanitizer."</p> <p>On February 26, 2025, at 9:42 a.m., registered nurse (RN)-A stated, "They (ULPs) go to sparks school where they go through hand hygiene and actually do it in front of someone and they are trained to do it before entering a room and after leaving a room, after toileting, before and after medication administration. They have to show how to apply gloves and take them off properly and when they should be wearing gloves. They should always wash their hands after removing gloves."</p> <p>The licensee's Hand Hygiene (Based upon the CDC Guideline Hand Hygiene in Healthcare Settings) policy, effective September 2011, indicated that hand hygiene should occur may occur multiple times during a single care episode and should preformed;</p> <ul style="list-style-type: none"> - Immediately before touching a patient; - Before performing aseptic techniques (indwelling device) or handling an invasive medical device; - Before moving from a soiled body site to a clean body site on same resident/patient; 	0 510		

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0 510	<p>Continued From page 6</p> <ul style="list-style-type: none"> - After touching a resident/patient or the resident ' s/patient ' s immediate environment; - After contact with blood, body fluids or contaminated surfaces; - Immediately before putting on gloves and after glove removal; - When hands are visibly soiled; - After caring for a person with known or suspected diarrhea; - After known or suspected exposure to spores; and - When caring for a person known or suspected to have norovirus. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p>	0 660		

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0 660	<p>Continued From page 7</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents, staff and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>ULP-E began providing cares to the residents on November 29, 2023.</p> <p>ULP-E's employee records lacked evidence of screening for active TB with either a two-step TST or blood test.</p> <p>On February 24, 2025, at 2:00 p.m., licensed assisted living director (LALD)-C stated, "We don't have [ULP-E] TB test, she transferred her from another one of our facilities and we do not have her original TB test, that did not transfer over with her, so all we have is her screening that we did when she came."</p> <p>The licensee's TB Infection Control Plan (144A.4798, Subd. 1) policy, effective February 2015, indicated all health care workers would</p>	0 660		
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0 660	Continued From page 8 receive a baseline TB screening upon hire using a two-step TST or single blood test to test for TB, and the results would be maintained in the employee ' s personnel record. No further information provided.	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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, 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). Findings include: During facility tour on February 25, 2025, from 1:30 p.m. to 5:00 p.m., with licensed assisted living director (LALD)-C and maintenance (M)-F, it was observed that not all resident rooms have carbon monoxide alarms, or the mechanical room	0 775		

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0 775	<p>Continued From page 9</p> <p>have a carbon monoxide detector connected to the fire alarm panel.</p> <p>Mechanical rooms that have fuel fired appliances will be equipped with a carbon monoxide detector connected to the fire alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State fire code.</p> <p>During a facility tour on February 25, 2025, at 3:30 p.m., LALD-C and M-F, verified the above listed observations while accompanying on the tour. LALD-C stated an addition was added to the facility and carbon monoxide detectors were installed in the mechanical rooms which connect to the fire alarm.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) day.</p>	0 775		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(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.</p>	0 810		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER THE LEGACY OF ST MICHAEL	STREET ADDRESS, CITY, STATE, ZIP CODE 4400 LANGE AVENUE NE SAINT MICHAEL, MN 55376
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 10</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During facility tour on February 25, 2025, from 1:30 p.m. to 5:00 p.m., with licensed assisted living director (LALD)-C and maintenance (M)-F, surveyor observed the posted evacuation plans</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 11</p> <p>lacked identification of resident rooms.</p> <p>Exit plan diagrams must be correctly labeled and accessible to staff, residents and visitors to reduce confusion and potential obstructions for egress in a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations.</p> <p>On February 25, 2025, LALD-C provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility.</p> <p>Training:</p> <p>The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-C stated they were using evacuation drills as training. No other training documentation was provided.</p> <p>The licensee failed to provide evacuation training to residents at least once per year. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.</p> <p>On February 25, 2025, at 3:30 p.m., LALD-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		

Minnesota Department of Health

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01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for four of four residents (R3, R4, R5 and R6).</p> <p>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</p>	01620		
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01620	<p>Continued From page 13</p> <p>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)</p> <p>The findings include:</p> <p>R3 R3 was admitted to the licensee and began receiving assisted living services on December 19, 2022.</p> <p>R3's diagnoses included type 2 diabetes, hypertension, and Alzheimer's disease.</p> <p>R3's signed Service Addendum to the Assisted Living Contract, dated February 18, 2025, indicated R3's services included toileting, bathing, monthly vitals, grooming, laundry, blood glucose monitoring, medication administration, oxygen management, oral cares, and dressing.</p> <p>R3's record included comprehensive assessments dated June 19, 2024, and October 7, 2024, indicated 110 days had passed between assessments, and a comprehensive assessments dated January 27, 2025, indicated 112 had passed between assessments.</p> <p>R4 R4 was admitted to the licensee and began receiving assisted living services on April 19, 2023.</p> <p>R4's diagnoses included congestive heart failure, hypertension, dementia, anxiety, and depression.</p> <p>R4's signed Service Addendum to the Assisted Living Contract, dated February 5, 2025,</p>	01620		

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01620	<p>Continued From page 14</p> <p>indicated R4's services included monthly vitals, toileting, medication administration, TED stockings, oxygen management, bathing, dressing, and laundry.</p> <p>R4's record included comprehensive assessments dated June 20, 2024, and October 22, 2024, indicated 124 days had passed between assessments, and a comprehensive assessments dated January 29, 2025, indicating 99 had passed between assessments.</p> <p>R5</p> <p>R5 was admitted to the licensee and began receiving assisted living services on April 6, 2024.</p> <p>R5's diagnoses included type 2 diabetes, hypertension, and major depressive disorder.</p> <p>R5's signed Service Addendum to the Assisted Living Contract, dated September 19, 2024, indicated R5's services included monthly vitals, toileting, medication administration, blood glucose monitoring, dressing, and laundry.</p> <p>R5's record included comprehensive assessments dated September 24, 2024, and December 26, 2024, indicated 93 days had passed between assessments.</p> <p>R6</p> <p>R6 was admitted to the licensee and began receiving assisted living services on February 19, 2024.</p> <p>R6's diagnoses included type 2 diabetes and dementia.</p> <p>R6's signed Service Addendum to the Assisted</p>	01620		

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01620	<p>Continued From page 15</p> <p>Living Contract, dated October 16, 2024, indicated R6's services included monthly vitals, bathing, toileting, medication administration, oral cares, dressing, grooming, escort services, meal assistance, and laundry.</p> <p>R6's record included comprehensive assessments dated June 20, 2024, and September 30, 2024, indicated 102 days had passed between assessments, and 149 had passed since completing an assessments.</p> <p>On February 26, 2025, at 8:15 a.m., licensed assisted living director (LALD)-C stated, "In December we, myself and [clinical nurse supervisor (CNS)-D] came in and took over and the assessments were late, and we have been playing catch up. So, you are going to find consistently that we are late with the majority of assessments."</p> <p>The licensee's Comprehensive Assessment Schedule effective July 2014, indicated a face to face assessment would be completed at least every 90 days.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01730 SS=F	<p>144G.71 Subd. 5 Individualized medication management plan</p> <p>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The</p>	01730		

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01730	<p>Continued From page 16</p> <p>facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:</p> <ul style="list-style-type: none"> (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current</p>	01730		

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01730	<p>Continued From page 17</p> <p>individualized medication management record for each resident to include all required content for two of two residents (R4 & R6).</p> <p>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)</p> <p>The findings include:</p> <p>R4 R4 was admitted to the licensee and began receiving assisted living services on April 19, 2023.</p> <p>R4's diagnoses included congestive heart failure, hypertension, dementia, anxiety, and depression.</p> <p>R4's signed Service Addendum to the Assisted Living Contract, dated February 5, 2025, indicated R4's services included monthly vitals, toileting, medication administration, TED stockings, oxygen management, bathing, dressing, and laundry.</p> <p>R4's Individualized Medication Management Plan dated January 28, 2025, lacked documentation of specific resident instructions related to the administration of medications.</p> <p>R6 R6 was admitted to the licensee and began receiving assisted living services on February 19, 2024.</p>	01730		

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01730	<p>Continued From page 18</p> <p>R6's diagnoses included type 2 diabetes and dementia.</p> <p>R6's signed Service Addendum to the Assisted Living Contract, dated October 16, 2024, indicated R6's services included monthly vitals, bathing, toileting, medication administration, oral cares, dressing, grooming, escort services, meal assistance, and laundry.</p> <p>R6's Individualized Medication Management Plan dated September 30, 2024, lacked documentation of specific resident instructions related to the administration of medications.</p> <p>On February 26, 2025, at 9:48 a.m., registered nurse (RN)-A stated, "I would say [specific resident instructions relating to the administration of medications] is in some peoples but not everybody's, and I would say it is based off of how the provider is writing those orders, if they don't write that we have not been adding that.</p> <p>The licensee's Medications & Treatments policy, effective August 2014, indicated the medication and treatment management plan would have documentation of specific instructions for medications or treatments.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01730		
01890 SS=D	<p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in</p>	01890		

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01890	<p>Continued From page 19</p> <p>the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of three residents (R5).</p> <p>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).</p> <p>The findings include:</p> <p>R5 was admitted to the licensee and began receiving assisted living services on April 6, 2024.</p> <p>R5's diagnoses included type 2 diabetes, hypertension, and major depressive disorder.</p> <p>R5's signed Service Addendum to the Assisted Living Contract, dated September 19, 2024, indicated R5's services included monthly vitals, toileting, medication administration, blood glucose monitoring, dressing, and laundry.</p> <p>On February 25, 2025, at 7:53 a.m., surveyor observed unlicensed personnel (ULP-I) administer 28 units of Humalog insulin to R5.</p>	01890		

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01890	<p>Continued From page 20</p> <p>R5's Humalog insulin pen lacked a date open sticker indicating the date the insulin pen was opened and the date the insulin pen would expire.</p> <p>On February 25, 2025, at 7:59 a.m., ULP-I stated, "Based on how many units he get this pen would have been opened last week sometime, but it should have a date open sticker on it and I will let the nurses know so they can take care of it."</p> <p>On February 26, 2025, at 9:46 a.m., registered nurse (RN)-A stated, when insulin pens are taken out of the fridge to be used employees need to date that they are opening it and put their initials on it.</p> <p>The licensee's Medications & Treatments policy, effective August 2014, indicated, "Any medication received from pharmacy in manufacturer box, bag, or container, should be kept in the original packaging. Once opened for use medication should be labeled with the specific date of first use."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		

Type: Full
Date: 02/24/25
Time: 11:45:08
Report: 1041251040

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Legacy Of St Michael
4400 Lange Avenue Ne
St Michael, MN55376
Wright County, 86

Establishment Info:

ID #: 0038589
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634970171
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.

LINDSAY MILLS CFPM CERTIFICATE EXPIRED IN FEBRUARY 2025. SHE IS IN THE PROCESS OF RENEWING CERTIFICATE.

Comply By: 03/24/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

1. CLEAN CEILING VENT ABOVE DISH STORAGE RACK TO REMOVE DUST BUILD UP.

2. CLEAN FLOOR UNDERNEATH COOKLINE EQUIPMENT TO REMOVE FOOD AND DIRT BUILD UP.

Comply By: 03/03/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit

Location: WIPING CLOTH BUCKET IN PREP AREA

Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit

Location: DISHWASHER FINAL RINSE CYCLE

Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 02/24/25
Time: 11:45:08
Report: 1041251040
The Legacy Of St Michael

Food and Beverage Establishment Inspection Report

Process/Item: Prep Cooler
Temperature: 41 Degrees Fahrenheit - Location: HARD BOILED EGGS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 170 Degrees Fahrenheit - Location: MEATBALLS
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: HARD BOILED EGGS
Violation Issued: No

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

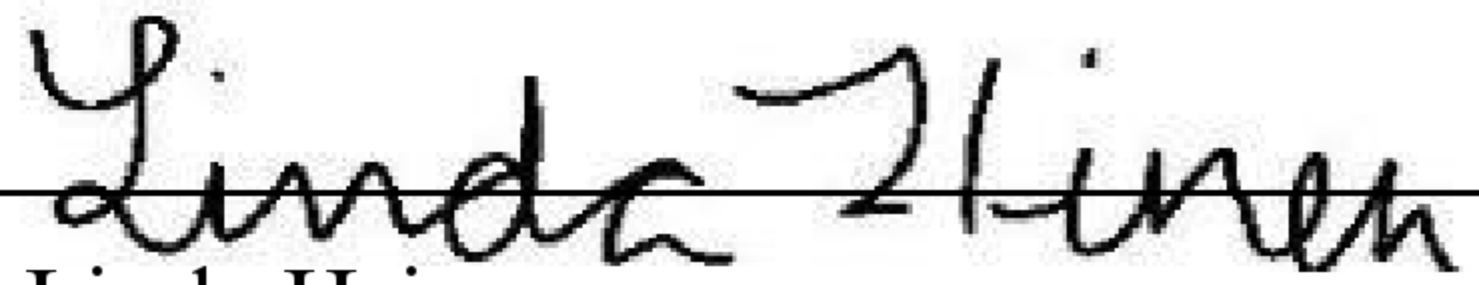
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1041251040 of 02/24/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____
Establishment Representative

Signed: 
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us