Electronically Delivered

May 18, 2023

Licensee
Carondelet Village
525 Fairview Avenue South
Saint Paul, MN 55116

RE: Project Number(s) SL28388015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28388	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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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: SL28388015 On April 24, 2023, through April 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 82 active residents, all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control by ensuring proper cleaning and disinfecting of a glucometer (blood sugar testing equipment) for one of one resident (R3). Further, the licensee failed to ensure proper glove use and hand hygiene (HH) during direct cares and medication administration for one of three employees (unlicensed personnel (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 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: HAND HYGIENE ULP-D was hired March 4, 2019, and provided direct care services for the residents of the facility. On April 24, 2023, from 3:00 to 3:54 p.m., ULP-D	0 510		

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0 510	Continued From page 3 was continuously observed during medication administration and cares. -at 3:01 p.m., ULP-D entered R5's apartment, and, without performing HH, donned gloves from a bag in her pocket, accessed R5's medication cabinet, and prepared medications for R5 by popping the pills from the medication card into a medicine cup. ULP-D returned the medication cards to the cabinet, removed gloves and gave the medication cup to R5 with a glass of water. Without performing HH, ULP-D then documented the task completed on her assignment sheet, picked up a trash bag, exited R5's room, and proceeded to the trash room, opened the door, and deposited the trash bag into the trash chute. ULP-D proceeded to R8's apartment. -at 3:17 p.m., without performing HH, ULP-D knocked and entered R8's apartment, donned gloves from the bag in her pocket, accessed R8's medication cabinet, and prepared medications for R8 by popping the pills from the medication cards into a medicine cup. ULP-D returned all the medication cards to the cabinet, except one empty card, that ULP-D stated would need to be taken to the nursing office for a refill. ULP-D then gave the medications to R8 with water, and, with gloves still on, hand-washed a few dishes that were in R8's sink with dish soap, rinsed and placed them on the counter to dry. ULP-D removed the soiled gloves, and without performing HH, gathered her assignment sheet, pen, and the empty medication card and exited R8's room. ULP-D indicated she would check on R9 next. -at 3:26 p.m., ULP-D rang the doorbell to R9's room, and entered, carrying R8's empty medication card. ULP-D briefly visited with R9 and then exited the room. ULP-D proceeded to the nursing office, set R8's empty medication card on registered nurse (RN)-H's desk and then	0 510		

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0 510	Continued From page 4 retrieved the ULP communication and documentation books to demonstrate the ULP documentation process for the surveyor. ULP-D returned the books, exited the nursing office, and used the elevator to go to the 3rd floor, to R4's room. -at 3:35 p.m., ULP-D knocked and entered R4's room, and touched R4's arm to arouse her. Without performing HH, ULP-D donned gloves from the bag in her pocket, accessed R4's medication cabinet, and prepared medications for R4 by popping the pills from the medication cards into a medicine cup. ULP-D returned the medication cards to the cabinet and administered the medications to R4 with water. With gloves still on, ULP-D then assisted R4 to use the toilet, performed perineal cares and changed R4's soiled brief. R4 ambulated independently back to her bed while ULP-D gathered the trash and removed the soiled gloves. Without performing HH, ULP-D covered R4 with a blanket, picked up the trash bag, and exited the room. ULP-D proceeded to the trash room opened the door, and deposited the trash bag into the trash chute. ULP-D then performed HH using a personal hand sanitizer attached to the nametag on the front of her shirt. On April 24, 2023, at 3:54 p.m., ULP-D stated caregivers were trained annually on several topics including infection control. ULP-D stated they were trained to use hand sanitizer or perform hand hygiene with soap and water for 20 seconds. ULP-D showed the surveyor the personal bottle of hand sanitizer attached to her name badge, and added there were also multiple sanitizer dispensers available in the hallways. ULP-D stated she usually performed hand hygiene when passing room trays and when she first entered the facility at the beginning of her	0 510		

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0 510	Continued From page 5	0 510		

shift. ULP-D further stated she felt the training she received regarding HH and infection control was very good, but added, "I maybe do not do it as much as I need to." ULP-D further stated she was taught, and understood, the importance of being consistent with hand hygiene.

On April 25, 2023, at 9:52 a.m., RN-H stated staff were trained to perform HH before and after gloving, and upon entering and leaving resident apartments. RN-H further stated soap and paper towels were provided in all the resident apartments. RN-H added individual hand sanitizer bottles were provided to staff and there were dispensers throughout the facility.

GLUCOMETER

R3 had diagnoses including diabetes mellitus, congestive heart failure, atrial fibrillation, and depression.

R3's service plan, dated August 16, 2022, indicated R3 received services including assistance with insulin administration and blood glucose (BG) monitoring.

ULP-E was hired October 21, 2019, and provided direct cares for the residents of the facility.

On April 25, 2023, at 9:11 a.m., ULP-E was observed to assist R3 with BG monitoring. ULP-E performed HH, donned gloves, and retrieved R3's glucometer from a locked cabinet in R3's apartment. ULP-E unzipped the pouch containing the glucometer and testing strips, removed the supplies and inserted a test strip into the glucometer. ULP-E cleansed R3's finger with an alcohol prep pad and pierced the finger with a disposable lancet. ULP-E touched the test strip to

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0 510	Continued From page 6 the blood drop, verbalized the BG level, and wiped remaining blood with a cotton ball. ULP-E disposed of the soiled supplies, removed gloves and performed HH. Without cleaning the glucometer, ULP-E returned it to the zipper pouch, documented the results, returned the meter and supplies to the cabinet and again performed HH. ULP-E then proceeded to assist R3 with medication administration. On April 25, 2023, at 9:35 a.m., ULP-E stated the glucometer was for use by R3 only and was not shared with other residents. ULP-E further stated she had never cleaned R3's glucometer, and was not sure who would clean it. On April 25, 2023, at 9:52 a.m., RN-H stated they did not clean the glucometers, and did not previously consider if it was something they should be doing. RN-H provided the glucometer manufacturer user's manual, which indicated the glucometer should be cleaned with "Super Sani-wipes" once per week and when blood was present. RN-H stated they would develop a process to ensure the glucometer was cleaned according to manufacturer directions. On April 25, 2023, at 12:13 p.m., clinical nurse supervisor (CNS)-B stated they did not do routine HH audits, but if they noted an issue with HH they would initiate audits of the caregivers. CNS-B further stated they did not have a glucometer cleaning routine in place, and was not sure what the current policy indicated. The licensee's Low-level Disinfection policy, 2020, indicated, "All items, other than disposables, are cleaned and disinfected following federal, state and local guidelines and manufacturers' recommendations."	0 510		

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0 510	Continued From page 7 The Accu-Chek Guide blood glucose meter user's manual, 2021, indicated, "Clean and disinfect the meter at least once per week and when blood is present on the surface of the meter." The manual further indicated, "If the meter is being operated by a second person who is providing testing assistance to the user, the meter and lancing device should be cleaned and disinfected prior to use by the second person." The CDC guidance titled, Hand Hygiene in Healthcare Settings, dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The licensee's Infection Control Standard Precautions Hand Hygiene policy, 2020, indicated, "1. Hand Hygiene should be performed: a. Before and after contact with the resident b. Before performing an aseptic task c. After contact with blood or body fluids d. After contact with visibly contaminated surfaces e. After contact with objects in the resident ' s room f. Before donning personal protective equipment g. After removing personal protective equipment". The licensee's Infection Control Standard Precautions Gloves policy, 2020, indicated hand	0 510		

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0 510	Continued From page 8 hygiene be performed before donning and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 9 On April 25, 2023, approximately from 11:00 a.m. to 12:40 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A, the regional engineering manager (REM)-I, and the environmental services director (ESD)-J. During the tour, survey staff observed the following: 1. Inside the 2nd and 3rd floor soiled linen rooms, survey staff observed sewer gas odor and the plumbing trap of the flushing rim sink in each room was completely dried out, which would allow sewer gas to enter the building environment creating unsafe and health risks to residents and employees. The ESD-J and the REM-I agreed and stated that the flushing rim sinks had not been used. Survey staff advised all unused plumbing traps in the building to be primed regularly to prevent sewer gas from entering the building and a water management plan be inplaced for the plumbing water system. 2. The integral backflow preventer on the faucet of the service (mop) sink located inside the housekeeping room next to room 365 was missing the backflow cap and comprised. In addition, the chemical soap dispenser connected to the faucet of this mop sink was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. 3. The corridor door hardware to resident room 365 was damaged. 4. The fire-rated doors for the laundry rooms (2nd and 3rd) of the assisted living parts of the building were wedged in open positions which compromised the fire safety of the corridors. All fire-rated doors must be in proper working order to maintain the integrity corridor to protect the residents, staff, and visitors during a fire.	0 800		

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0 800	Continued From page 10 All findings were visually and/or verbally verified by the REM-I and ESD-J accompanying the tour. On April 25, 2023, at approximately 2:45 p.m., during the exit interview the LALD-A, the REM-I, and the ESD-J acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	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: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 11 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide annual training for residents that can self-assist in their owner evacuation in the event of a fire and the minimum required evacuation drills. This has the potential to directly affect the safety of all residents receiving services, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 25, 2023, at approximately 1:45 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the regional engineering manager (REM)-I, and the environmental services director (ESD)-J. At approximately 2:00 p.m., document review and interview with the REM-I and the ESD-J indicated the following findings:	0 810		

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CARONDELET VILLAGE	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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0 810	Continued From page 12 1. The licensee lacked a record to show the required annual resident training for those that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. Resident training record for fire safety and evacuation was requested but was not available. 2. The drill records showed an insufficient number of employee fire safety and evacuation drills performed to date. Drill records received for review for the previous year 2022 and the year 2023, lacked records for December 2022, January 2023, February 2023, and March 2023. Survey staff explained to the REM-I and ESD-J that the minimum required frequency of two evacuation drills for employees is twice per year per shift with at least one evacuation every other month. On April 25, 2023, at approximately 2:45 p.m., during the exit interview the licensed assisted living director (LALD)-A, the REM-I, and the ESD-J acknowledged the above findings. The LALD-A stated that she had thought resident training on fire safety was performed and will look for records. Survey staff noted that the resident training record will be honored if received by our office by the end of 4/26/2023. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950		

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0 950	Continued From page 13 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, contact information of designated representative, or indication they declined to designate a representative, for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 950		

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0 950	Continued From page 14 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted August 13, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R2 was admitted January 29, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R3 was admitted on April 12, 2022, and received services including assistance with insulin administration and blood glucose (BG) management. R4 was admitted February 1, 2017, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, laundry, and medication management. R5 was admitted March 17, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, and medication management. R1, R2, R3, R4, and R5's assisted living contract's dated, March 25, 2022, July 23, 2021, April 4, 2022, March 21, 2022, and March 21, 2022, respectively, lacked designation of a representative, contact information of designated	0 950		

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0 950	Continued From page 15 representative, or indication they declined to designate a representative. On April 26, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A stated the resident records lacked documentation of a designated a representative, including contact information of the designated representative. On April 26, 2023 at 2:11 p.m., surveyor requested, via email, to provide a copy of the licensee's designated representative policy. On April 28, 2023, at 11:09 a.m., LALD-A indicated, via email, LALD-A spoke with licensee's corporate office and verified the Residency Agreement outlined the terms of the contract as well as the role of the designated responsibilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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0 970	Continued From page 16 Based on interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On April 24, 2023, at 10:30 a.m., during the entrance conference, a copy of the the facility's contract was requested. The licensee's contract included the following sections, on page 17-18, section 8, "waiving the licensee's liability for safety of the resident and their property: 8. Assumption of Risks a.) Personal Property of Resident: Resident assumes primary responsibility for all risk for harm to or loss of any of Resident's personal property. Resident is encouraged, if so desired, to secure an Apartment or renter's insurance policy to protect against such loss. b.) Motor Vehicle Use; No Liability of Owner: Resident is solely responsible for personal injury, property damage, or other loss as a result of Resident's owning, maintaining, operating and/or parking of a motor vehicle on or off the premises of the Community. c.) Other Losses or Damages: Resident acknowledges familiarity with the Apartment, the	0 970		

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0 970	Continued From page 17 premises and services of the Community and is therefore willing to, and does, assume the risks associated with occupancy. Resident further acknowledges that neither Owner nor any of its affiliates is an insurer of Resident's safety." In addition, on page 15-16, section 7, indicated "responsibilities of the resident under this agreement: 7. Responsibilities of Resident k.) Be responsible for the costs associated with the following, caused by the acts or failure of Resident, pets, Resident's agents, family members, or guests, whether intentional or unintentional, and whether or not under Resident's control or direction. 1.) any loss, property damage, or repair or service (including plumbing problems) or injury to any person; and 2.) any loss or damage caused by inappropriate use of any feature of the Apartment, including as examples only and without limitation, doors or windows being left open, faucets being left open, toilet use, stoves being left on, and refrigerators being left open." On April 26, 2023 at 9:58 a.m., licensed assisted living director (LALD)-A confirmed the facility's assisted living contract contained a waiver of liability. Licensee's policy on waivers of liability was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01470	Continued From page 18	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 19 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received Assisted Living orientation to include all required content for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired October 21, 2019, and began providing assisted living services August 1, 2021.	01470		

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01470	Continued From page 20 On April 25, 2023, at 9:11 a.m., ULP-E was observed to assist R3 with blood glucose (BG) monitoring and medication administration. ULP-E's employee record lacked documentation the following orientation topics were completed: -an overview of the appropriate Assisted Living statutes 144 G and rules; and -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On April 26, 2023, at 1:07 p.m., licensed assisted living director (LALD)-A stated she was not sure why ULP-E did not get the initial Assisted Living orientation training, but she would look into it to see if it was covered in another training or documented elsewhere. On April 28, 2023, at 3:18 p.m., LALD-A stated, via email, the licensee did not have a policy regarding orientation to Assisted Living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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01500	Continued From page 21 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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01500	Continued From page 22 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training on the required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired October 21, 2019, and provided direct cares for the residents of the facility. On April 25, 2023, at 9:11 a.m., ULP-E was observed to assist R3 with BG monitoring and medication administration. ULP-E's employee record lacked documentation of 8 hours of annual training completed within the last year, including the following required topics: -training on reporting of maltreatment of	01500		

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01500	Continued From page 23 vulnerable adults under section 626.557; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 26, 2023, at 1:07 p.m., licensed assisted living director (LALD)-A stated the training documented for ULP-E for the past year was not the required annual training provided to staff. LALD-A stated ULP-E's previous year annual training was mislabeled, causing the required annual training course to not be assigned. On April 28, 2023, at 3:18 p.m., LALD-A stated, via email, the licensee did not have a policy regarding annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	02040		

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02040	Continued From page 24 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On April 25, 2023, at approximately 2:00 p.m., a documentation review and interview were performed with the regional engineering manager (REM)-I, and the environmental services director (ESD)-J relating to the memory care safety risk/vulnerability assessment and mitigation plan, indicated the licensee lacked memory care site-specific safety risk assessment and mitigation plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. This finding was evident as the documentation provided for the review was an all-hazard risk assessment as part of the emergency	02040		

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02040	Continued From page 25 preparedness plan under Appendix B (Carondelet HVA Village) and no memory care related plan documentation was provided for review. The findings were confirmed during the interview with the REM-I that the licensee lacked the memory care site-specific provisions. On April 25, 2023, at approximately 2:45 p.m., during the exit interview the LALD-A, the REM-I, and the ESD-J acknowledged the above findings. During the exit interview survey, staff discussed the findings and explained that all potential safety risks and/or vulnerabilities on and around the property including the resident apartment stovetops, electric panels inside resident rooms, cleaning chemicals, small appliances, and any other risks must be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28388	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(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
02110	Continued From page 26 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required policies and procedures for assisted living with dementia care (ALFDC), were provided to residents or the resident's legal and /or designated representative at the time of move-in for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	02110		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 27 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: The licensee had a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021. R1 was admitted August 13, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R1's record included a revised Residency Agreement, signed September 23, 2022, indicating R1 received a resident handbook and, "certain other notices and reference materials provided under Minnesota Law," and provided an internet address to the licensee's web site where documents may be viewed, including the required dementia care policies and procedures. R2 was admitted January 29, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R2's record included a revised Residency Agreement, signed September 27, 2022, indicating R2 received a resident handbook and, "certain other notices and reference materials provided under Minnesota Law," and provided an internet address to the licensee's web site where documents may be viewed, including the required dementia care policies and procedures. R3 was admitted April 12, 2022, and received services including assistance with housekeeping,	02110		

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	28388	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

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02110	Continued From page 28 medication management, and blood glucose management. R3's record included a revised Residency Agreement, signed October 3, 2022, indicating R3 received a resident handbook and, "certain other notices and reference materials provided under Minnesota Law," and provided an internet address to the licensee's web site where documents may be viewed, including the required dementia care policies and procedures. R4 was admitted February 1, 2017, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, laundry, and medication management. R4's record included a revised Residency Agreement, signed September 19, 2022, indicating R4 received a resident handbook and, "certain other notices and reference materials provided under Minnesota Law," and provided an internet address to the licensee's web site where documents may be viewed, including the required dementia care policies and procedures. R5 was admitted March 17, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, and medication management. R5's record included a revised Residency Agreement, signed September 19, 2022, indicating R5 received a resident handbook and, "certain other notices and reference materials provided under Minnesota Law," and provided an internet address to the licensee's web site where documents may be viewed, including the required	02110		

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02110	Continued From page 29 dementia care policies and procedures. R1, R2, R3, R4, and R5's resident records all lacked evidence a resident or resident representative were provided the 10 required dementia care policies and procedures addressed in 144G.82 Subd. 3. at the time of move-in to the ALFDC-licensed facility. On April 28, 2023, at 3:18 p.m., LALD-A stated the dementia care policies were included in an admission packet, provided upon move-in. LALD-A further stated they did not have documentation to show the residents, or their representatives, received the 10 required dementia care policies upon move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center	02240		

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02240	Continued From page 30 (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for four of five residents (R1, R2, R4, R5). This practice resulted in a level two violation (a	02240		

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02240	Continued From page 31	02240		

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:

The licensee had a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021.

R1 was admitted August 13, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management.

R2 was admitted January 29, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management.

R4 was admitted February 1, 2017, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, laundry, and medication management.

R5 was admitted March 17, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, and medication management.

R1, R2, R3, and R5's Assisted Living Residency Agreement, dated March 25, 2022, July 23, 2021, March 21, 2022, and March 21, 2022, respectively, all lacked a signature acknowledging

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02240	Continued From page 32 receipt of the current Assisted Living Bill of Rights. R1, R2, R4, and R5's records included a revised Residency Agreement, signed September 23, 2022, September 27, 2022, September 19, 2022, and September 19, 2022, respectively, indicating they received the Assisted Living Bill of Rights. R1, R2, R4, and R5's resident records all lacked written acknowledgement they received the "Minnesota Bill of Rights for Assisted Living Residents" at the time of move-in to the facility. On April 28, 2023 at 3:18 p.m., licensed assisted living director (LALD)-A confirmed, via email, that the Minnesota assisted living bill of rights was provided, but not signed to acknowledge receipt. LALD-A also indicated in the same email that the licensee had records of the residents signing the Minnesota assisted living bill of rights prior to September 2021. MN AL Notice of Resident Rights Policy, dated August 1, 2021, indicated, "[Licensee] will notify residents of their rights before the initiation of services." The policy further indicated, "Written acknowledgement of the resident's receipt of the assisted living bill of rights will be obtained. If a written acknowledgement of receipt of the bill of rights cannot be obtained, an acknowledgement of why it cannot be, will be obtained and documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days Based on interview and record review, the licensee failed to ensure the current "Minnesota	02240		

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02240	Continued From page 33 Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for four of five residents (R1, R2, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021. R1 was admitted August 13, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R2 was admitted January 29, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with medication management. R4 was admitted February 1, 2017, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, laundry, and medication management. R5 was admitted March 17, 2020, under the comprehensive license, and began receiving assisted living services August 1, 2021, including assistance with housekeeping, and medication	02240		

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02240	Continued From page 34 management. R1, R2, R3, and R5's Assisted Living Residency Agreement, dated March 25, 2022, July 23, 2021, March 21, 2022, and March 21, 2022, respectively, all lacked a signature acknowledging receipt of the current Assisted Living Bill of Rights. R1, R2, R4, and R5's records included a revised Residency Agreement, signed September 23, 2022, September 27, 2022, September 19, 2022, and September 19, 2022, respectively, indicating they received the Assisted Living Bill of Rights. R1, R2, R4, and R5's resident records all lacked written acknowledgement they received the "Minnesota Bill of Rights for Assisted Living Residents" at the time of move-in to the facility. On April 28, 2023 at 3:18 p.m., licensed assisted living director (LALD)-A confirmed, via email, that the Minnesota assisted living bill of rights was provided, but not signed to acknowledge receipt. LALD-A also indicated in the same email that the licensee had records of the residents signing the Minnesota assisted living bill of rights prior to September 2021. MN AL Notice of Resident Rights Policy, dated August 1, 2021, indicated, "[Licensee] will notify residents of their rights before the initiation of services." The policy further indicated, "Written acknowledgement of the resident's receipt of the assisted living bill of rights will be obtained. If a written acknowledgement of receipt of the bill of rights cannot be obtained, an acknowledgement of why it cannot be, will be obtained and documented."	02240		

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CARONDELET VILLAGE	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

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02240	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/24/23*
Time: 13:30:00
Report: 1025231101

Food and Beverage Establishment Inspection Report

Location:
Carondelet Village
525 Fairview Avenue South
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0037489
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6516955000
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.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

Remove the wye adapter with the two control valves from the utility sink.

Comply By: 04/28/23

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

Provide drain covers for cook line drain, bistro drain, any other floor drains which may be missing drain covers.

Comply By: 05/31/23

Surface and Equipment Sanitizers

"Sink & Surface" DDBSA: = OK at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Hot Water: = at N/A Degrees Fahrenheit
Location: Dishwashing
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Ambient
Temperature: 41 Degrees Fahrenheit - Location: Upright cooler, 2 door, expo
Violation Issued: No

Process/Item: HB egg
Temperature: 41 Degrees Fahrenheit - Location: Bistro display
Violation Issued: No

Process/Item: Ham
Temperature: 41 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Pork
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler, cooling from ambient
Violation Issued: No

Process/Item: Cut melon
Temperature: 38 Degrees Fahrenheit - Location: AL expo cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Bistro cooler
Violation Issued: No

Process/Item: Chicken
Temperature: 32 Degrees Fahrenheit - Location: Thawing, walk-in cooler
Violation Issued: No

Process/Item: Chicken
Temperature: 41 Degrees Fahrenheit - Location: Upright cooler, grill
Violation Issued: No

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

Dishwasher not fully operational during inspection - sanitize cycle not working. Dishes to be washed and rinsed in the dish machine and then sanitizing using the available Sink and Surface sanitizer. Quat ammonia also available, test kit available for Sink and Surface and quat ammonia. Irreversible temperature change strips and a min/max thermometer (needs batteries) available. Care Center dish machine to be used - Care Center reported as skilled nursing facility, reported the dish machine is a Hobart unit and has been verified to be reaching temperatures necessary for sanitizing.

Discussed employee health and hygiene, illness reporting and exclusion, temperatures for holding and cooking, highly susceptible population requirements, eggs and egg uses, chicken (pre-cooked product in upright cooler), equipment, food contact surfaces, pest control, quarantine room delivery and returnables.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231101 of 04/24/23.

Certified Food Protection Manager: Angela Rein

Certification Number: FM110800 Expires: 04/24/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Angela

Signed: _____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231101

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 04/24/23
Time In 13:30:00
Time Out

	Address	City/State	Zip Code	Telephone
Carondelet Village	525 Fairview Avenue South	St Paul, MN	55116	6516955000

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037489		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A N/O — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 04/24/23

Inspector (Signature) [signature]