Electronically Delivered

October 22, 2024

Licensee
Villages Of St. Clare
101 9th Street
Mora, MN 55051

RE: Project Number(s) SL20246015

Dear Licensee:

On October 14, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 18, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 9, 2024

Licensee
Villages of St. Clare
101 9th Street
Mora, MN 55051

RE: Project Number(s) SL20246015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 18, 2024, 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.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20246	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGES OF ST CLARE	101 9TH STREET MORA, MN 55051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20246015-0 On July 15, 2024, through, July 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 34 resident(s); 34 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 17, 2024, issued for SL20246015-0, tag identification 1290. On July 18, 2024, at 8:50 a.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of I.	0 000	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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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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 of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 15, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 2 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on July 17, 2024, from 10:00 a.m. to 11:15 a.m., with maintenance (M)-J, the surveyor made the following observations of facility disrepair: The existing door closers were removed from both fire-resistant rated laundry room doors. The fire-resistant rated laundry room doors are required to automatically close, and latch as designed, installed, and approved at the time of construction.	0 800		

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0 800	Continued From page 3 The fire-resistant rated doors would not automatically close and latch on both trash rooms. The fire-resistant rated trash room doors are required to automatically close, and latch as designed, installed, and approved at the time of construction. Documentation was not available verifying the building fire alarm system was annually tested and maintained. The building fire alarm system is required to be annually tested and maintained in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511, National Fire Protection Association (NFPA) 72 and manufactures instructions. On July 18, 2024, at 9:00 a.m., licensed assisted living director (LALD)-B, wrote in an email there was not documentation available to verify the fire alarm system was tested and maintained annually. During a facility tour on July 17, 2024, at 11:15 a.m., M-J, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 4 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees with access to residents and resident records had a cleared background study completed via NetStudy 2.0 for 12 of 22 employees (clinical nurse supervisor/CNS-A, unlicensed personnel (ULP-F, ULP-D, ULP-G, ULP-H, ULP-I, ULP-K, ULP-L, ULP-M, ULP-N, ULP-O, ULP-P). In addition, the licensee failed to ensure background studies were affiliated with the assisted living facility for 8 of 22 employees (ULP-Q, ULP-R, ULP-S, ULP-U, ULP-V, ULP-W, ULP-X, ULP-Y). This had the potential to affect all residents, employees, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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). This resulted in an immediate correction order on July 17, 2024. The findings include:	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 5 LACKING CLEARED BACKGROUND STUDY CNS-A CNS-A was hired on May, 31, 2006, to provide direct care services to residents of the facility. CNS-A's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for CNS-A. CNS-A obtained her RN license on November 1, 1994. ULP-F ULP-F was hired on September 13, 2023, to provide direct care services to residents of the facility. ULP-F's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-F. ULP-D ULP-D was hired on June 15, 2017, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-D. ULP-G ULP-G was hired on February 15, 2021, to provide direct care services to residents of the facility. ULP-G's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-G. ULP-H ULP-H was hired on January 5, 2022, to provide	01290		

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01290	Continued From page 6 direct care services to residents of the facility. ULP-H's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-H. ULP-I ULP-I was hired on August 16, 2023, to provide direct care services to residents of the facility. ULP-I's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-I. ULP-K ULP-K was hired on February 15, 2021, to provide direct care services to residents of the facility. ULP-K's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-K. ULP-L ULP-L was hired on January 2, 2023, to provide direct care services to residents of the facility. ULP-L's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-L. ULP-M ULP-M was hired on June 7, 2023, to provide direct care services to residents of the facility. ULP-M's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m.,	01290		

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01290	Continued From page 7 indicated a background study had not been submitted for ULP-M. ULP-N ULP-N was hired on January 2, 2023, to provide direct care services to residents of the facility. ULP-N's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-N ULP-O ULP-O was hired on June 8, 2022, to provide direct care services to residents of the facility. ULP-O's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-O. ULP-P ULP-P was hired on December 20, 2023, to provide direct care services to residents of the facility. ULP-P's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 17, 2024, at 10:34 a.m., indicated a background study had not been submitted for ULP-P. None of the above employees were observed to be under direct supervision during the survey. BACKGROUND STUDY NOT AFFILIATED ULP-Q ULP-Q was hired on June 4, 2020, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-Q, submitted through a separate license	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 8 operated by the attached skilled nursing facility. ULP-R ULP-R was hired on April 30, 2020, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-R, submitted through a separate license operated by the attached skilled nursing facility. ULP-S ULP-S was hired on June 22, 2022, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-S, submitted through a separate license operated by the attached skilled nursing facility. ULP-U ULP-U was hired on May 28, 2013, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-U, submitted through a separate license operated by the attached skilled nursing facility. ULP-V ULP-V was hired on January 5, 2020, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-V, submitted through a separate license operated by the attached skilled nursing facility. ULP-W ULP-W was hired on February 26, 2024, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-W, submitted through a separate license operated by the attached skilled nursing facility. ULP-X ULP- X was hired on May 22, 2024, to provide	01290		

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01290	Continued From page 9 direct care services to residents of the facility. The licensee provided a background study for ULP-X, submitted through a separate license operated by the attached skilled nursing facility. ULP-Y ULP-Y was hired on December 20, 2017, to provide direct care services to residents of the facility. The licensee provided a background study for ULP-Y, submitted through a separate license operated by the attached skilled nursing facility. On July 17, 2024, at 11:15 a.m., the background study clearance letters or all staff were reviewed with CNS-A, licensed assisted living director (LALD)-B, RN-C, and human resources (HR)-Z. The employees listed without documentation of a cleared background study had a paper copy of a study being completed under the licensee's prior comprehensive home care license, which was closed August 31, 2023. HR-Z stated she was the sensitive information person (SIP) and submitted each background study information for the licensee, which did not allow for her to enter with the health facility identification number (HFID) for this license as an option. The licensee's Background Studies policy dated April 24, 2024, noted the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. It also noted "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received." No further information was provided.	01290		

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01290	Continued From page 10 TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed after supervisor review on July 18, 2024, however, noncompliance remains at a scope and level of widespread, level three (l).	01290		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include person-centered planning and service delivery. This practice resulted in a level one violation (a violation that has no potential to cause more than	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20246	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGES OF ST CLARE	101 9TH STREET MORA, MN 55051

(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
01560	Continued From page 11 a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living license. On July 15, 2024, at 10:20 a.m., a request was made for a copy of the description of the training program for dementia care. On July 18, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-A and registered nurse (RN)-C stated they did not have a description of the dementia training to include the person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 12 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1	01650		

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VILLAGES OF ST CLARE	101 9TH STREET MORA, MN 55051

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01650	Continued From page 13 R1's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R1 received services including assistance with compression wraps, medication administration, showers, and toileting. However, it lacked: - the methods of monitoring assessments of the resident; and - the methods of monitoring staff providing services. R2 R2's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R2 received services including assistance with dressing, showers, diabetes management and medication administration. However, it lacked: - the methods of monitoring assessments of the resident; and - the methods of monitoring staff providing services. R3 R3's Assisted Living Home Care Service Agreement dated June 4, 2024, indicated R3 received services including assistance with showers and medication administration. However, it lacked: - the methods of monitoring assessments of the resident; and - the methods of monitoring staff providing services. On July 16, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated the service plan included the schedules of monitoring, but lacked the method. In addition, CNS-A stated the same template was utilized for all residents. The licensee's Service Plan policy dated August 1, 2022, noted the service plan would include the	01650		

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VILLAGES OF ST CLARE	101 9TH STREET MORA, MN 55051

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01650	Continued From page 14 schedule and method for the next planned assessment or monitoring and the schedule and method for the next planned monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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VILLAGES OF ST CLARE	101 9TH STREET MORA, MN 55051

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01730	Continued From page 15 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. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 15, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility.	01730		

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01730	Continued From page 16 R1 On July 16, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her apartment. R1's diagnoses included hypertension and diabetes mellitus type II. R1's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R1 received services including assistance with compression wraps, medication administration, showers, and toileting. R1's prescriber orders dated September 27, 2023, included one diuretic, one supplement, and one anti-diabetic medication. R1's July 2024 Medication Record listed medications as prescribed, times to administer, and staff initials through July 15, 2024, to indicate the medications had been given. R1's record lacked a medication management plan to include: - type of medication storage system, based on the resident's needs; and - procedures for staff to notify a registered nurse (RN) when problems arose. R2 R2's diagnoses included insomnia, glaucoma, and diabetes mellitus type II. R2's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R2 received services including assistance with dressing, showers, diabetes management and medication administration.	01730		

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01730	Continued From page 17 R2's prescriber orders dated August 7, 2023, included one statin, one diuretic, and two insulins. R2's July 2024 Medication Record listed medications as prescribed, times to administer, and staff initials through July 15, 2024, to indicate the medications had been given. R2's record lacked a medication management plan to include: - type of medication storage system, based on the resident's needs; and - procedures for staff to notify a RN when problems arose. R3 R3's Assisted Living Home Care Service Agreement dated June 4, 2024, indicated R3 received services including assistance with showers and medication administration. R3's prescriber orders dated December 20, 2023, included one diuretic, two medications to treat high blood pressure, and one supplement. R3's July 2024 Medication Record listed medications as prescribed, times to administer, and staff initials through July 15, 2024, to indicate the medications had been given. R3's record lacked a medication management plan to include: - procedures for staff to notify a RN when problems arose. On July 16, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated the storage information was not filled in for R1 and R2, the form lacked the procedures for staff to notify the RN when a problem arose, and said the same	01730		

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01730	Continued From page 18 template was utilized for all residents receiving medication management. The licensee's Medication Management Individualized Plan policy dated May 2, 2022, noted the licensee would develop and maintain a current individualized medication management plan for each resident including a description of storage of medications based on the resident's needs and preferences, and the procedures for staff notifying a registered nurse when a problem arose with medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 19 review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 16, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her apartment. R1's diagnoses included hypertension and diabetes mellitus type II. R1's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R1 received services including assistance with compression wraps, mediation administration, showers, and toileting. R1's prescriber orders dated September 27, 2023, noted: - acetaminophen 650 milligrams (mg) by mouth as needed for pain/temperature, maximum one dose every 24 hours. R1's July 2024 Medication Record noted: - acetaminophen 650 mg by mouth every 4-6 hours as needed for minor pain or temperature. On July 16, 2024, at 2:10 p.m., clinical nurse	01760		

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01760	Continued From page 20 supervisor (CNS)-A stated the transcription did not match, and added the language on the medication record was similar to the standing orders verbiage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations for one of two residents (R2) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 16, 2024, at 8:30 a.m., the surveyor	01880		

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01880	Continued From page 21 observed R2's medication storage with unlicensed personnel (ULP)-D. R2's opened Humalog KwikPen (prefilled insulin pen) was observed to be stored in the resident's refrigerator in her apartment. ULP-D stated she was trained to keep this particular insulin in the refrigerator both before and after opening. On July 16, 2024, at 1:45 p.m., clinical nurse supervisor (CNS)-A stated according to the manufacturer's instructions, the insulin pen should not be refrigerated after opened. The manufacturer's instructions for Humalog dated revised August 2023 noted in-use pens should not be refrigerated. The licensee's Medication Storage policy dated May 2, 2022, noted medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced	01970		

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01970	Continued From page 22 by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) who received treatments managed be the provider. 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: During the entrance conference on July 15, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to residents at the facility. On July 16, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in her apartment. R1's diagnoses included hypertension and diabetes mellitus type II. R1's Assisted Living Home Care Service Agreement dated July 1, 2024, indicated R1 received services including assistance with compression wraps, mediation administration, showers, and toileting. R1's Treatment/Therapy Management Plan dated April 1, 2023, noted R1 received assistance with compression garments.	01970		

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01970	Continued From page 23 On July 16, 2024, at 2:10 p.m., CNS-A stated R1 had an order for the stockings, but was unable to locate it in R1's record. The licensee's Medication & Treatment Orders - Renewal policy dated May 2, 2022, noted medication and treatment orders must be renewed at least every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *07/15/24*
Time: 11:00:13
Report: 1037241152

Food and Beverage Establishment Inspection Report

Location:
Villages Of St Clare
101 9th Street
Mora, MN55051
Kanabec County, 33

Establishment Info:
ID #: 0037561
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206792576
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.

SEND A FULL TIME EMPLOYEE TO A FOOD SAFETY COURSE AND APPLY FOR CFPM. APPLICATION WILL BE SENT WITH REPORT.

Comply By: 08/15/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST CERTIFICATE ONCE OBTAINED.

Comply By: 08/15/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Type: Full
Date: *07/15/24*
Time: 11:00:13
Report: 1037241152
Villages Of St Clare

Food and Beverage Establishment Inspection Report

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

DISCUSSED CFPM REQUIREMENTS. ALYCIA R IS ANFP REGISTERED, BUT TOOK CLASS 1/3/24. ALYCIA HAD UNTIL 7/3/24 TO APPLY FOR CFPM CERTIFICATE. SEND A FULL TIME EMPLOYEE TO A FOOD SAFETY COURSE AND OBTAIN THE CFPM CERTIFICATE AFTER SUCCESSFUL COMPLETION OF COURSE.

FOOD IS PREPPED AND COOKED IN THE NURSING HOME SIDE. TEMPERATURES TAKEN AND LOGGED UPON ARRIVAL TO ASSISTED LIVING SERVING KITCHEN. DISHED BROUGHT BACK TO NURSING HOME FOR CLEANING AND SANITIZING.

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 1037241152 of 07/15/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1037241152

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/15/24
Time In 11:00:13
Time Out

Villages Of St Clare	Address: 101 9th Street	City/State: Mora, MN	Zip Code: 55051	Telephone: 3206792576
License/Permit #: 0037561	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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
Surpervision							
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		

			COS	R
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		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) **Date:** 07/19/24

Inspector (Signature)