Electronically Delivered

August 12, 2025

Licensee
Dellwood Gardens
753 East 7th Street
Saint Paul, MN 55106

RE: Project Number(s) SL29953016

Dear Licensee:

On July 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 24, 2025. This follow-up survey verified that the facility is in substantial 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,

Renee L Anderson

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

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June 5, 2025

Licensee
Dellwood Gardens
753 East 7th Street
Saint Paul, MN 55106

RE: Project Number(s) SL29953016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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,

Renee L Anderson

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29953	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLWOOD GARDENS	753 EAST 7TH STREET SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #29953016-0 On April 21, 2025, through April 24, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 87 residents, all of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license. An immediate correction order was identified on April 23, 2025, issued for SL29953016-0, tag identification 2310. An immediate correction order was identified on April 24, 2025, issued for SL29953016-0, tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk of the above deficiencies. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	0 480		

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0 480	Continued From page 2 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including completing a facility TB risk assessment. 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	0 660		

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0 660	Continued From page 4 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's facility TB risk assessment indicated it had been completed April 21, 2025, during the time of survey. On April 21, 2025, at 2:51 p.m., clinical nurse supervisor (CNS)-B stated she had not done a TB risk assessment prior to the survey date, and it looked like it had been missed for 2024. The licensee's 8.16 Tuberculosis Screening policy, dated February 5, 2024, indicated the facility would maintain a current community TB risk assessment and the assessment would be updated annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 5 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on April 24, 2025, from 10:30 a.m. to 2:30 p.m., surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency. On April 24, 2025, from 10:30 a.m. to 2:30 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810		

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0 810	Continued From page 7 UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On April 24, 2025, at 12:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No other training documentation was provided. On April 24, 2025, at 12:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 9 (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, their legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four (4) days for one of one resident (R4). 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). R4's progress note, dated April 17, 2025, at 7:26 p.m., indicated R4 had returned to the facility after a transitional care unit stay. On April 24, 2025, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated R4 had been sent to the hospital on March 3, 2025, and from the hospital to a transitional care unit on March 26, 2025. CNS-B further stated R4 returned to the licensee's facility on April 17, 2025. -at 4:19 p.m., CNS-B stated their process was to notify the OOLTC if a resident were outside of the	01060		

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01060	Continued From page 10 facility greater than 24hrs. On April 25, 2025, at 8:42 a.m., CNS-B stated the form they usually sent to the ombudsman should have been in R4's record, but she was unable to locate it. CNS-B further stated she thought it had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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 observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study, prior to providing services, for one of three employees (unlicensed personnel	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 11 (ULP)-G). 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). The findings include: The licensee's health facility identification number (HFID) was 29953 and the licensee provided assisted living services beginning August 1, 2021. ULP-G was hired on July 16, 2018, and provided direct care services to the licensee's residents. On April 22, 2025, during continuous observation from 8:10 a.m. to 8:35 a.m., the surveyor observed ULP-G assisting residents with medication administration and obtaining vital signs. ULP-G's employee record contained a background study clearance form dated July 16, 2018, affiliated with a different HFID (29952). The employee record lacked a current, cleared background study affiliated with the current licensed assisted living HFID 29953. The licensee's current employee list, dated April 21, 2025, included 14 current employees that did not appear on the DHS Net Study 2.0 roster for HFID 29953, including ULP-G. On April 23, 2025, at 3:15 p.m., licensed assisted	01290		

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01290	Continued From page 12 living director (LALD)-A stated she thought the 14 employees might all be listed under the licensee's previous HFID (29952), and someone from their human resource department was looking into it. On April 24, 2025, at 8:32 a.m., the surveyor reviewed the DHS Net Study 2.0 website. The website indicated HFID 29952 had been disabled April 9, 2022, and was no longer active. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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01370	Continued From page 13 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one employee (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, 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: ULP-E was hired November 5, 2023, and provided direct care services to residents.	01370		

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01370	Continued From page 14 On April 22, 2025, at 7:25 a.m., ULP-E was observed assisting the licensee's residents with morning cares and medication administration. ULP-E's employee record lacked the following required trainings and competency evaluations: - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional. On April 23, 2025, at 2:15 p.m., licensed assisted living director (LALD)-A stated there had been a "glitch" in their system and none of the ULP had been assigned the trainings: they had only been assigned to management. LALD-A further stated moving forward the trainings would be assigned to all ULP. The licensee's 5.02 Competency Training Evaluations policy, dated February 5, 2024, indicated when a registered nurse or licensed health professional staff of [licensee] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 15 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-D, 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, 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	01440		

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01440	Continued From page 16 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D and ULP-E were hired January 27, 2023, and November 5, 2023, respectively, and provide direct cares for the licensee's residents. On April 21, 2025, at 1:50 p.m., ULP-D was observed assisting the licensee's residents with medication administration. On April 22, 2025, at 7:25 a.m., ULP-E was observed assisting the licensee's resident with medication administration. ULP-D and ULP-E's records both lacked documentation the RN conducted direct supervision of the ULP performing a delegated task within 30 days of performing the task. On April 24, 2025, at 4:19 p.m., clinical nurse supervisor (CNS)-B stated documentation of the 30-day supervisions were given to an employee to be filed. CNS-B further stated the employee was no longer working for the licensee and it looked like she did not file the documents. The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated February 5, 2024, indicated supervision of unlicensed personnel would be conducted within 30 calendar days after the individual begins working for the licensee and first performs delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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

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01500	Continued From page 18 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees completed eight hours annual training including all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-E, registered nurse (RN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01500		

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01500	Continued From page 19 ULP-E ULP-E was hired November 5, 2023, and provided direct care services to residents. On April 22, 2025, at 7:25 a.m., ULP-E was observed assisting the licensee's residents with morning cares and medication administration. ULP-E's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -infection control techniques; -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; -review of the provider's 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. RN-F RN-F was hired March 6, 2017, and provided direct care services to residents and supervision to staff. On April 23, 2025, during the course of the survey, RN-F was observed providing supervision to the unlicensed personnel. RN-F's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63,	01500		

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01500	Continued From page 20 Subd.5, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -infection control techniques; -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; -review of the provider's 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 23, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated it looked like ULP-E and RN-F had not completed the required annual training. LALD-A further sated the licensee held group sessions for the education, and she was not sure why the employees did not sign up for the sessions. The licensee's 5.06 Annual Required Staff Training policy, dated February 5, 2024, indicated annual training would include all the required topics as required under 144G.63, Subd.5. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics	01540		

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01540	Continued From page 21 specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame for two of three employees (unlicensed personnel (ULP)-D, registered nurse (RN)-F). 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: The licensee held an Assisted Living with Dementia Care License and provided assisted living services as of August 1, 2021.	01540		

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01540	Continued From page 22 ULP-D ULP-D was hired January 27, 2023, and provided direct care services to residents. On April 21, 2025, at 1:52 p.m., ULP-D was observed assisting R2 with medication administration. ULP-D's file lacked evidence ULP-D completed two hours of required annual dementia training. On April 25, 2025, at 8:48 a.m., licensed assisted living director (LALD)-A stated ULP-D had not completed any of her annual education, and she was not sure why. RN-F RN-F was hired March 6, 2017, and provided direct care services to residents and supervision to staff. On April 23, 2025, during the course of the survey, RN-F was observed providing supervision to the unlicensed personnel. RN-F's employee file lacked at least eight hours of initial dementia training in the required topics, within 80 working hours of the employment start date, and at least two hours of annual dementia training. On April 22, 2025, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated she it looked like RN-F's initial education had not been done, but she would "dig" more for it. On April 25, 2025, 2024, at 12:16 p.m., LALD-A stated she was unable to find any additional documentation that RN-F completed the required	01540		

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01540	Continued From page 23 dementia training, and she was not sure why it had not been completed. The licensee's 5.03 Dementia Training policy, dated September 1, 2021, indicated direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date, and two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620		

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01620	Continued From page 24 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's service plan, dated March 20, 2025, indicated R5 received services including assistance activities of daily living, behavior management, and medication administration. On April 22, 2025, at 8:15 a.m., unlicensed personnel (ULP)-G was observed assisting R5 with placing hearing aids and obtaining vital signs. R5's record included an initial comprehensive nursing assessment, dated August 24, 2023, and a subsequent RN reassessment, dated September 15, 2023, completed 22 days (greater than 14 days) after the date services were	01620		

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	29953	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLWOOD GARDENS	753 EAST 7TH STREET SAINT PAUL, MN 55106

(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
01620	Continued From page 25 initiated. On April 23, 2025, at 4:56 p.m., licensed assisted living director (LALD)-A stated R5's 14-day assessment was completed by a previous nurse and the nurse had been delayed in getting it done. The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated February 4, 2024, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document and opened date on time sensitive medication for two of two residents (R2, R4). 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	01890		

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01890	Continued From page 26 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 the potential to affect a large portion or all of the residents). The findings include: R2 R2's service plan, dated December 3, 2024, indicated R2 received services including assistance with insulin administration daily. On April 22, 2025, at 7:25 a.m., the surveyor observed R2's medications with unlicensed personnel (ULP)-E. The medications included an insulin glargine (a long-acting insulin, for diabetes) pen. The pen had a sticker that read "use pen up to 28 days after first use, then throw away." ULP-E stated there was usually a "date opened" sticker on the pen, and she was not sure why it was not there. ULP-E stated she could not tell when the pen was first used because it was missing and opened date. ULP-E called registered nurse (RN)-F. RN-F came to R2's room and removed the pen. -at 7:35 a.m., RN-F provided a new insulin pen that included a sticker with the opened date. RN-F stated she was not sure why the first pen was not dated when it was opened, and it should have been. R3 R3's service plan, dated May 3, 2024, indicated R3 received services including assistance with insulin administration twice daily. On April 22, 2025, at 8:35 a.m., the surveyor observed R3's medications with ULP-G. The	01890		

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01890	Continued From page 27 medications included an insulin glargine pen. The pen lacked an opened date. ULP-G stated insulin pens usually had a date opened sticker on them. ULP-G called RN-F who instructed ULP-G to remove the pen, obtain a new pen from the medication storage refrigerator, and date the new pen. The manufacturer's prescribing information for the use of Lantus, insulin glargine injection, revised June 2023, indicated the medication should be discarded 28 days after first use. The licensee's 7.11 Medication Storage policy, dated February 5, 2024, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R4) who utilized bed rails.	02310	During the course of the survey, the licensee took action to mitigate the imminent risk of the above deficiencies. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 28 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). The findings include: R4's service plan, dated May 3, 2024, indicated R4 received services including assistance with medication administration, dressing, and housekeeping. R4's bed rails/bar assessment, dated April 17, 2025, indicated R4 utilized hospital style half side bed rails for "getting in and out of bed, and independence with repositioning." On April 22, 2025, at 8: 35 a.m., the surveyor observed a hospital style bed in R4's room, with half bed rails on both sides of the upper part of the bed. The bed rails were firmly attached to the bed, and were observed in the "down" position. On April 23, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated there was more than one resident with hospital style bed rails, and she was responsible for monitoring the bed rails. CNS-B further stated she was not aware there were entrapment zone measurements that needed to be documented for the bed rails and had not documented the measurements for any of the bed rails in the facility. The FDA Guidance for Industry and FDA Staff	02310		

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02310	Continued From page 29 Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The Hospital Bed Safety Workgroup (HBSW) and International Electrotechnical Commission (IEC) recommend that the space be less than 120 mm (4 ¾ inches), representing head breadth. Zone 2 is the space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. The FDA recommends that this space be small enough to prevent head entrapment, less than 120 mm (4 ¾ inches). Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The FDA recommends a dimensional limit of less than 120 mm (4 ¾ inches) for the area between the inside surface of the rail and the compressed mattress. Zone 4 is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. The FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches). The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the	02310		

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02310	Continued From page 30 best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most	02310		

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02310	Continued From page 31 up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *04/21/25*
Time: 09:15:06
Report: 8058251096

Food and Beverage Establishment Inspection Report

Location:
Dellwood Gardens
753 East 7th Street
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0029617
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Dellwood Gardens

Phone #: 6517769511
ID #: 39232

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

0 PPM CL IN DISH MACHINE - SEE COMMENTS

Comply By: 04/21/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

PEELING PAINT ABOVE DISH WASHER

Comply By: 05/30/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Chlorine: = OPPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

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

Process/Item: LASAGNA
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

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

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

HRD INSPECTOR TAMMY CARLSON

DISH MACHINE DOES NOT RUN AT A TEMPERATURE HIGH ENOUGH TO SANITIZE, THERE IS NO CHEMICAL SANITIZER ATTACHED TO DISH MACHINE, A CHLORINE/DETERGENT PRODUCT IS USED BUT TEST STRIPS COULD NOT VERIFY ITS ABILITY TO SANITIZED AND REGISTERED AS ZERO PPM

- USE 3 COMP SINK TO SANITIZE UNTIL DISH MACHINE SANITIZING OPERATION CAN BE VERIFIED

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 8058251096 of 04/21/25.

Certified Food Protection Manager: JOHN MADISON

Certification Number: 24775 Expires: 11/04/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOHN MADISON
SUPERVISOR

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us