DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 14, 2021

Administrator
Saint Therese Of Woodbury
7555 Bailey Road
Woodbury, MN 55129

RE: Project Number(s) SL32379015-1

Dear Administrator:

On December 6, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 15, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered
October 4, 2021

Administrator
Saint Therese of Woodbury
7555 Bailey Road
Woodbury, MN 55129

RE: Project Number(s) SL32379015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. 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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32379	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF WOODBURY	7555 BAILEY ROAD WOODBURY, MN 55129

(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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 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: SL32379015 On September 13, 2021, through September 15, 2021, 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 58 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
0 480 SS=F	144G.41 Subdivision 1 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all 58 residents of the facility. 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).	0 480		

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0 480	Continued From page 2 The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated September 13, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for four of four residents (R1, R2, R3, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	0 630		

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0 630	Continued From page 3 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1, R2, R3, and R5's records lacked individualized abuse prevention plans to include statements of the specific measures to be taken to minimize the risk of abuse to that person. R1 R1's diagnoses included, but was not limited to, vascular dementia. R1's Vulnerability Assessment/Abuse Prevention Plan dated April 12, 2021, indicated vulnerabilities to include: moderate memory loss, inappropriate judgment, hearing loss, and a history of falls with need for assistance with ambulation. The abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R1. R2 R2's diagnoses included, but was not limited to, dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance. R2's Vulnerability Assessment/Abuse Prevention Plan dated January 13, 2021, indicated vulnerabilities to include: moderate memory loss, bilateral hearing loss, and history of falls. The abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R2.	0 630		

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0 630	Continued From page 4 On September 14, 2021, at approximately 7:45 a.m., observed R2 receive personal cares and medication administration from unlicensed personnel (ULP)- G. R3 R3's diagnoses included, but was not limited to, congenial malfunction of aorta. R3's Vulnerability Assessment/Abuse Prevention Plan dated June 11, 2020, indicated vulnerabilities to include: mild memory loss, hearing loss, cognition, unsteady gait, unable to use stairs. The abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R3. On September 14, 2021, at approximately 9:35 a.m., observed R3 in his room using a wheelchair to move around in his apartment, R3 stated, "it is getting difficult to stand without support". R5 R5's diagnoses included, but was not limited to, Alzheimer's disease. R5's Vulnerability Assessment/Abuse Prevention Plan dated April 7, 2021, indicated vulnerabilities to include: moderate memory loss, hearing loss, and unsteady gait. The abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R5. On September 15, 2021, at 9:45 a.m., R5 stated she was independent with cares, but received medications and assistance with application of Ted socks by the licensee staff. R5 stated she lives in the assisted living because of "my memory," and "I don't hear well."	0 630		

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0 630	Continued From page 5 On September 15, 2021, at 9:45 a.m., executive director (ED)-A and registered nurse (RN)-B confirmed the vulnerability assessment tools lacked the above required content. The licensee's Freedom from Abuse, Neglect & Exploitation Policy Content & Procedures policy dated November 27, 2018, verified "annually and as needed, each resident and guest will have a safety assessment completed, identifying potential vulnerabilities (i.e., cognitive, physical, psychosocial, environmental and communication)." The "interdisciplinary team will identify vulnerabilities and interventions on the resident or guest care plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 6 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees unlicensed personnel (ULP-C and ULP-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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: ULP-C ULP-C had a hire date of December 2, 2019. On September 14, 2021, from 7:00 a.m. through	0 650		

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0 650	Continued From page 7 9:30 a.m., ULP-C was observed to provide assisted living services to include medication administration and application of Ted stockings for the licensee's residents. ULP-C's record lacked evidence of eight hours of initial dementia training; initial training on change of condition, personal hygiene and grooming, basic nutrition, meal preparation, food safety, modified diets, client status, basic knowledge of body functioning, reading and recording temperature, pulse, and respirations; and the physical, emotional, cognitive and developmental needs of the resident. ULP-G ULP-G had a hire date of June 22, 2020. On September 14, 2021, from approximately 7:20 a.m. to 9:30 a.m., ULP-G was observed to provide personal care services and medication administration for the licensee's residents. ULP-G's record lacked evidence of eight hours of initial dementia training; initial training on change of condition, personal hygiene and grooming, basic nutrition, meal preparation, food safety, modified diets, client status, basic knowledge of body functioning, reading and recording temperature, pulse, and respirations; and the physical, emotional, cognitive and developmental needs of the client. On September 15, 2021, at approximately 3:55 p.m., executive director (ED)-A indicated the licensee had conducted the trainings with ULP-C and ULP-G, but was not sure why the information was missing from the employee's records. The licensee's Assisted Living Orientation-ULP	0 650		

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0 650	Continued From page 8 Staff policy dated August 1, 2021, verified "newly hired unlicensed personal will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations." The policy lacked documentation the orientation and training would be included in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure the first floor laundry room included a fire protection sprinkler. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On September 14, 2021, at 2:45 p.m. survey staff	0 830		

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0 830	Continued From page 9 toured the facility with the executive director(ED)-A and director of plant operations (DPO)-H. The laundry room on the first floor did not contain a fire protection sprinkler. On September 14, 2021, at approximately 3:15 p.m., DPO-H verified the laundry room did not have a fire protection sprinkler and stated he was surprised it had been missed during prior inspections. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
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;	01500		

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01500	Continued From page 10 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased 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 interview and record review, the licensee failed to ensure employees received at	01500		

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01500	Continued From page 11	01500		

least eight hours of annual training for each 12 months of employment for two of two employees unlicensed personnel (ULP-C and ULP-G) with training records reviewed.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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-C and ULP-G employee records lacked evidence of eight hours of annual training.

ULP-C
ULP-C had a hire date of December 2, 2019.

On September 14, 2021, from 7:00 a.m. through 9:30 a.m., ULP-C was observed to provide assisted living services including medication administration and application of Ted stockings for the licensee's residents.

ULP-G
ULP-G had a hire date of June 22, 2020.

On September 14, 2021, at approximately 7:45 p.m., observed ULP-G provide personal care services and medication administration to R2 in her room.

On September 15, 2021, at 3:55 p.m., executive director (ED)-A stated annual training had not been completed for ULP-C and ULP-G due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32379	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF WOODBURY	7555 BAILEY ROAD WOODBURY, MN 55129

(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
01500	Continued From page 12 Covid-19. ED-A stated the licensee had a plan and a curriculum to complete annual training for 2021 for the licensees' employees. The licensee's Annual Training policy, dated February 24, 2021, verified "direct-care staff will complete 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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 review, the licensee failed to ensure medication was administered as prescribed for two of five residents (R2, and R5) with records reviewed.	01760		

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01760	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's insulin pens lacked labels for the opening date or the expiration date. R2's record lacked evidence of blood glucose, blood pressure and pulse monitoring. R2's diagnoses included, but was not limited to, diabetes. R2's service plan dated August 12, 2021, indicated services to include not all inclusive; secured living setting with routine observation, total assistance with activities of daily living, extensive assist with eating, two-person transfer and medication administration. R2's prescriber orders dated September 14, 2021, included orders for blood pressure monitoring of systolic blood pressure greater than 180, diastolic blood pressure less than 55, pulse less than 55, Bumetadine tablet one milligram (mg) by mouth one time a day for edema, Clonidine HCL tablet 0.1 mg give one tablet by mouth every 8 hours as needed for systolic blood pressure greater than 180, Humalog solution cartridge 100 unit/milliliter (insulin lispro) inject 5 units subcutaneous in the morning for type 2	01760		

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01760	Continued From page 14 diabetes, Humalog solution cartridge 100 unit/milliliter (insulin lispro) inject 9 units subcutaneous two times a day for type 2 diabetes, Lantus solution 100 unit/ml (insulin glardine) inject 16 units subcutaneous one time a day for type 2 diabetes, Lisinopril tablet 10 mg give one tablet by mouth one time daily for hypertension. On September 14, 2021, at approximately 8:10 a.m., observed ULP-G administer morning medications including; Bumetadine tablet one milligram (mg) by mouth one time a day for edema, Lisinopril tablet 10 mg, give one tablet by mouth one time daily for hypertension, Buspirone Hcl tablet 5 mg, give one tablet by mouth two times a day for anxiety disorder, Citalopram Hydrobromide tablet give 20 mg by mouth one time a day for depressive order, Sennosides-Docusate sodium tablet 8.6-50 mg give one tablet by mouth one time a day for constipation, Lantus solution 100 unit/ml (insulin glargine) inject 16 units subcutaneous one time a day for type 2 diabetes, and Humalog solution cartridge 100 unit/milliliter (insulin lispro) inject 5 units subcutaneous in the morning for type 2 diabetes. On September 15, 2021, at approximately 10:00 a.m., RN-B stated they had forgotten to label the insulin pens with the open date, she also stated they had missed the orders to include the blood pressure, blood glucose and pulse monitoring and that they will start monitoring immediately. The licensee's policy Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated August 1, 2021, indicated "documentation after assistance with medication administration consistent with our	01760		

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01760	Continued From page 15 agency's procedures for documenting the MAR". R5 R5's diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD). The resident received medication administration by the licensee's unlicensed personnel (ULP). R5's prescriber orders dated September 14, 2021, included orders for Albuterol Sulfate HFA Aerosol Solution 108 mcg/act, two puffs orally daily for wheezing, and Advair Diskus Aerosol Powder Breath Activated 250-50 mcg/dose, one puff orally two times a day every Monday through Saturday for Chronic Obstructive Pulmonary Disease/COPD. On September 14, 2021, at 8:45 a.m., ULP-C was observed to administer R5's oral medications and one puff of Albuterol Sulfate. ULP-C administered a second puff of Albuterol Sulfate a few seconds later. After approximately two minutes, the employee administered one puff of Advair Diskus Aerosol, and asked the resident swish and spit with water prior to leaving the apartment. When queried, ULP-C stated to wait two minutes between different types of inhalers, and was not aware of the requirement to wait five minutes between inhaler use. On September 15, 2021, at 9:45 a.m., RN-B verified the protocol for inhaler administration is to wait five minutes between different types of inhalers, and stated the information would be added to the care plan. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, verified the "unlicensed personnel that will provide assistance	01760		

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01760	Continued From page 16 with medication, treatment and therapy administration will be trained and competency tested by the RN [registered nurse]" and would include medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility lacked documentation of a hazard vulnerability or safety risk assessment performed around the licensee's property. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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02040	Continued From page 17 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The Findings include: A hazard vulnerability assessment must be performed on and around the property to protect the dementia care residents from harm. On September 14, 2021, at approximately 4:45 p.m., the licensee provided survey staff with the Facility Assessment and the NFPA 99-2012 Utility Assessment documentation for review. The documentation did not address specific hazards and mitigation from the property to protect all potential hazards that has potential to directly affect all memory care residents. a. Specific assessment and details of prevention measures to protect the residents from elopement. b. Specific assessment and mitigation to protect residents from an emergency or fire evacuation from the outdoor fenced area that has a secured gate when in use by the resident(s), and the key accessed door both from the inside and outside. c. Specific assessment and mitigation to protect residents from the ponds and the busy highway/roads surrounding the property. On September 14, 2021, at approximately 4:45 p.m., executive director(ED)-A and director of plant operations (DPO)-H verified the facility lacked documentation of a hazard vulnerability or safety risk assessment performed around the property and verified hazards must be assessed and mitigated to protect the residents from harm. No further information was provided.	02040		

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02040	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	144G.91 Subd. 4 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 standards, medical or nursing standards with bed rails, for one of one resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included, but were not limited to: congenial malfunction of aorta and mild memory loss. R3's service plan dated September 2, 2021, indicated R3 received assistance with: medication administration, assistance with dressing and grooming, toileting, escorts to and from meals, and resident monitoring every 90 days.	02310		

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02310	Continued From page 19 R3's Vulnerability Assessment/Abuse Prevention Plan dated June 11, 2020, indicated R3 used a wheelchair for ambulation/mobility. R3's Physical Device Evaluation dated September 3, 2021, indicated R3 had a right-side grab bar provided by the family. The same document indicated physical therapy recommended R3 use a bedside handle to assist with transfers. On September 14, 2021, at 10:15 a.m., R3 was asked about the side rail, R3 stated he used the side rail to reposition in bed, to sit up at the side of bed, and to assist to get out of bed. R3 also said the bed rail "was very wobbly" and could easily be moved. On September 14, 2021, at approximately 10:30 a.m. in the presence of the surveyor, ULP-C measured R3's side rail: the rail on the right side of the bed was rectangular shaped and measured 13" in width, and 8" in height (in the mid-section). The rail was one piece with no cross-bars but had a thick tape used to close opening to less than four inches wide. ULP-C also confirmed the bed rail could easily be moved back and forth, and was not secured to the bed frame. When the mattress was lifted, it revealed the rail was one piece not bolted or otherwise secured to the bed frame; the side rail was stabilized by the weight of the mattress. When the surveyor grasped the side rail, it easily moved. No gap was observed between the rail and mattress. The licensee's undated policy titled Bed Safety, indicated the licensee shall strive to provide a safe sleeping environment for the resident, and	02310		

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SAINT THERESE OF WOODBURY	7555 BAILEY ROAD WOODBURY, MN 55129

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02310	Continued From page 20 ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), A Guide to Bed Safety revised April 2010, included the 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 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." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *09/13/21*
Time: 11:23:17
Report: 8058211141

Food and Beverage Establishment Inspection Report

Location:
Saint Therese of Woodbury
7555 Bailey Rd
Woodbury, MN55129
Washington County, 82

Establishment Info:
ID #: N000001
Risk: High
Announced Inspection: No

License Categories:
,

Expires on: 12/31/21

Operator:
Katelyn Nowack
Phone #: 651-209-9103
ID #: 001

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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS HELD IN THE FOLLOWING COOLERS WERE ABOVE MIN. TEMP REQUIREMENTS FOR COLD HOLDING: DISPLAY COOLER IN BISTRO, LTC RESIDENT COOLER, MEMORY CARE PREP COOLER BASE - SEE COMMENTS

Comply By: 09/11/21

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT HAS RECENTLY SUBMITTED APPLICATION FOR CFPM

Comply By: 11/08/21

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

ADJUST, REPAIR OR REPLACE COOLERS LISTED IN COMMENTS

Comply By: 09/30/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: DISPENSER/BUCKET
Violation Issued: No

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: SPRAY BOTTLE BISTRO
Violation Issued: No

Hot Water: = --- at 161 Degrees Fahrenheit
Location: BISTRO DISH MACHINE
Violation Issued: No

Hot Water: = --- at 165 Degrees Fahrenheit
Location: LTC DISH MACHINE
Violation Issued: No

Hot Water: = --- at 166 Degrees Fahrenheit
Location: MC DISH MACHINE
Violation Issued: No

Hot Water: = --- at 160 Degrees Fahrenheit
Location: DISH MACHINE MAIN KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HAM SAND.
Temperature: 43 Degrees Fahrenheit - Location: DISPLAY COOLER BISTRO
Violation Issued: Yes

Process/Item: HARD BOILED EGG
Temperature: 44 Degrees Fahrenheit - Location: LTC RESIDENT COOLER
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 45 Degrees Fahrenheit - Location: LTC RESIDENT COOLER
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 43 Degrees Fahrenheit - Location: MEMORY CARE PREP COOLER
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 39 Degrees Fahrenheit - Location: MEMORY CARE RESIDENT COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: SERVER STATION COOLER
Violation Issued: No

Process/Item: CHICKEN
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER (COOLED FROM 9/10)
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

Process/Item: TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: PICKLE
Temperature: 37 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: HAM
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: TOMATO VEG MIX
Temperature: 135 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: BEEF SOUP
Temperature: 181 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

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

COMMENTS:

DISPLAY COOLER IN BISTRO - INSTRUCTED TO ADJUST AND MONITOR
RESIDENT COOLER IN LTC - ADJUSTED TEMP DOWN AND INSTRUCTED TO MONITOR/TEST 9/12/21
PREP COOLER IN MEMORY CARE, INSTRUCTED TO ADJUST AND MONITOR

SPOKE WITH PIC REGARDING COVID PROTOCOL

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058211141 of 09/13/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
JOSHUA KEEN
MGR

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us