Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 4, 2023

Licensee
Lexington Landing
900 Old Lexington Avenue
Saint Paul, MN 55116

RE: Project Number(s) SL36884015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36884	A. BUILDING: _____ B. WING _____	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON LANDING	900 OLD LEXINGTON AVENUE SAINT PAUL, MN 55116

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36884015-1 On August 28, 2023, through September 5, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 55 residents, all received services under the provider's Assisted Living with Dementia Care Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs for two of four residents (R3, R6). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 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 Facility with Dementia Care (ALFDC) license. The facility was licensed for a bed capacity of 64 residents and at the time of survey had a census of 55 residents, all of whom received services. On August 28, 2023, at 10:25 a.m., during the entrance conference, licensed assisted living director (LALD)-A indicated the night shift operated with two unlicensed personnel (ULP). One ULP is designated to the secured memory care floor and one ULP is designated to the unsecured assisted living floors. LALD-A stated the assisted living floors of the facility did not offer a two person transfer or use of a mechanical lift. Furthermore, LALD-A indicated an assist of two transfer with mechanical lift is only offered in the secured memory care floor. R3 R3 was admitted October 25, 2022, to the unsecured assisted living portion of the facility and had diagnoses to include dementia, lumbar spinal stenosis (narrowing of the spinal canal in lower back), and hypertension. R3's service plan dated August 14,2023, indicated R3 received services to include assistance with meals, showers, toileting, lotion treatment, and medication administration.	0 470		

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0 470	Continued From page 3 R3's record included a falls injury form dated July 22, 2023, at 2:00 a.m., which included a short-term intervention at the time of the fall which stated, "call emergency medical services (EMS) for transport help off the floor." R6 R6 was admitted August 15, 2022, to the unsecured assisted living portion of the facility and had diagnoses to include type 2 diabetes, mixed Alzheimer's and vascular dementia, and expressive aphasia (difficulty with communication). R6's service plan dated January 4, 2023, indicated R6 received services to include assistance with "extensive assist AM," showers, toileting, compression stockings, and medication administration. R6's record included a falls injury form dated July 22, 2023, at 12:48 a.m. Additionally, R6's resident progress note dated July 22, 2023, at 1:20 a.m., included a fall progress note, completed by the on-call triage nurse which stated, "Instructed the RA to follow the fall protocol. The RA called for lifting help because of the lack of power. Notify the family when possible. Call with changes in condition or with concerns." On August 28, 2023, at 2:00 p.m., registered nurse (RN)-E reviewed the falls injury reports for R3 and R6 with surveyor. RN-E stated EMS was called for both R3 and R6 on July 22, 2023, during the night shift. RN-E also pointed out the call to EMS was for lift assistance, and neither R3 nor R6 was transported to the emergency department for medical assistance. RN-E further stated the resident is charged by the facility for a lift assist by EMS. RN-E stated the home care	0 470		

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0 470	Continued From page 4 services coordinator (HSC)-F completed the billing portions. -2:12 p.m., HSC-F stated both R3 and R6 were billed for a lift assist by EMS on July 22, 2023, during the night shift. -3:15 p.m., licensed assisted living director (LALD)-A stated, it would be very difficult to hire additional staff for the night shift. LALD-A also stated she was not sure if it was accurate that EMS could not be used for a lift assistance with a resident fall. Further, LALD-A indicated she would need to talk with her corporate team about this requirement. The licensee's AL Fall Prevention and Management Policy updated October 14, 2021, indicated "3. Post Fall Management: a. The resident assistant will complete along with the Occurrence Report the [Licensee's] Fall Protocol and will notify the nurse/on-call nurse prior to assisting the resident up; b. The resident assistant who witnessed the fall or first responded must complete Resident Occurrence Report, Resident Fall Data Collection Form and leave it for nurse; c. The nurse or resident assistant if directed will notify the responsible party. The nurse will notify the provider; d. The nurse will review the occurrence report and Fall Follow Up Form and will: i. Assess all factors contributing to the fall event such as environment, equipment, medication factors and which interventions were in place at the time of the fall using Fall Follow Up form as a guideline. ii. Recommend interventions and changes to plan of care to prevent repeat fall; e. The On-Call Nurse for those sites where a nurse is not present after hours will recommend temporary interventions to the resident assistant to prevent repeat fall based on the information	0 470		

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0 470	Continued From page 5 gathered from the falls huddle; and f. An entry into the medical record will be completed to include resident appearance at time of discovery, resident response to event, evidence of injury, location, medical provider notification, responsible party notification, nursing actions taken." The licensee's MN AL Direct Care Staff Plan Policy dated August 12, 2021, included "To provide an adequate number of qualified direct-care staff to meet our residents' needs 24-hours a day, seven-days a week." In addition, "3. The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24- hours a day, seven-days a week and will be adequate to address: a. Each resident's needs as identified in the service plan and assisted living contract; b. Each resident's acuity level as determined by the most recent assessment; c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; and d. Ability to respond promptly to individual resident emergencies and to emergency, life safety, and disaster situations." The licensee's uniform disclosure of Assisted Living Services and Amenities dated November 16, 2022, indicated "Number of unlicensed direct care staff typically scheduled per shift: Day Shift: 3; Evening Shift: 3; and Night Shift: 2." Further included "Mechanical lift: assist of 2 transfer, [Licensee] provides the equipment, slings, and staff for full lift transfers. Available only in Arbor."	0 470		

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0 470	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 30, 2023, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 1, 2023, from approximately 9:15 a.m. to 10:15 a.m., document review and interview with the regional engineering manager	0 800		

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0 800	Continued From page 8 (REM)-H and the environmental services director (ESD)-I, regarding the use and occupancy separation of the building for the licensed 64 ALFDC on record indicated that the licensee failed to have the two-hour horizontal occupancy separation between the licensed assisted living from the unlicensed independent living parts of the building. During the interview and documentation review of the building evacuation plan, survey staff explained that the plans show a 2-hour vertical separation on each floor throughout the 5-story building for licensed and unlicensed living units but failed to show the required 2-hour horizontal separation between the licensed assisted living and unlicensed independent living on all the 4th and 5th floors of the building. The REM-H verified the findings. On September 1, 2023, approximately from 10:30 a.m. to 1:15 p.m., survey staff toured the facility with REM-H and ESD-I. During the tour, survey staff observed the following: -Inside living unit 503, the tub drain failed to drain as survey staff observed standing water when the tub was filled. -Inside living unit 504, the door lock hardware was misaligned such locking for privacy was difficult. The ESD-I stated that he had been adjusting the door alignments throughout the building due to the new building settling. -In living unit 509, there were multiple wall cracks in the walls of the bedroom and living areas. The ESD-I stated that these are new building settling cracks and they will look at them again. -The ADA push button failed to open the trash room door when pushed. On September 1, 2023, at approximately 2:15 p.m., during the exit interview, the licensed	0 800		

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0 800	Continued From page 9 assisted living director-A, the REM-H, and the ESD-I acknowledged the above findings. The REM-H stated that he will gather and send the builidng code plans for further consideration. Additional PDFs of the architectural building code plan sheets were received via email on September 5, 2023, at 8:50 a.m. from the REM-H. The review of the building code sheets indicated that the horizontal separation ceiling assembly throughout the 5-story building was constructed with a 1-hour construction assembly. Therefore, the horizontal separation between the licensed assisted living from the unlicensed independent living at the ceiling assembly is a 1-hour construction. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting	0 900		

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0 900	Continued From page 10 documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written contract with the required content for all residents of the assisted living with dementia care 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). The findings include: The licensee's Current Resident Roster dated August 28, 2023, indicated R4 and R8, a married couple, resided at the assisted living facility with dementia care (ALFDC). R4	0 900		

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0 900	Continued From page 11 R4 admitted to the licensee on January 17, 2023. R4's residency agreement service plan dated August 28, 2023, indicated services received to include appointment reminders, medication monitoring and management, weekly laundry, medication administration, nail care, nurse assist, shower assist, verbal cues for grooming, and basic wound care. R4's record lacked a signed assisted living contract. R8 R8 admitted to the licensee January 26, 2023. R8's residency agreement service plan dated September 5, 2023, indicated services received to include medication monitoring and management, weekly laundry, medication administration, shower assist, and verbal cues for grooming. R8's record included an assisted living residency agreement contract identifying both R8 and R4, dated effective January 14, 2023. R4 and R8 did not have their own contracts. R4 and R8's record lacked individual contracts as required. On August 29, 2023, at 11:40 a.m., licensed assisted living director (LALD)-A stated the licensee had R4 and R8 on one signed contract for both residents. LALD-A stated the licensee believed the licensee could have one contract for both residents. LALD-A stated all couples who were living together in the facility and in other facilities owned by the same owner only have one contract. LALD-A stated she reached out to the	0 900		

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LEXINGTON LANDING	900 OLD LEXINGTON AVENUE SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 12 licensee's attorney, and everyone feels this is an acceptable practice per tenant laws. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01620 SS=E	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 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 interview and record review, the	01620		

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	36884	A. BUILDING: _____ B. WING _____	09/05/2023

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01620	Continued From page 13 licensee failed to ensure the registered nurse (RN) conducted a resident reassessment not to exceed 14 calendar days from the initiation of services for three of four residents (R2, R4, R7). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted August 1, 2022, and had diagnoses to include type 2 diabetes and atrial fibrillation (abnormal heart rhythm). R2's service plan dated March 29, 2023, indicated R2 received services to include assistance with meals, housekeeping, laundry, showers, escorts, blood glucose testing, and medication management. R2's record included an initial assessment completed August 1, 2022, and a 14-day reassessment completed August 19, 2022 (18 days after start of services). R4 R4 was admitted to licensee on January 17, 2023, and had diagnosis to include dementia, anxiety, hypertension, hyperlipidemia (high cholesterol), Rheumatoid arthritis, and high blood pressure.	01620		

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	36884	A. BUILDING: _____ B. WING _____	09/05/2023

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01620	Continued From page 14 R4's current service plan dated February 24, 2023, indicated R4 received services to include assistance with medication monitoring, medication management, medication administration, weekly laundry, nail care, showers, verbal cues for grooming and cares, and vital signs as needed. R4's record included an initial assessment completed January 9, 2023, and resident moved into licensee on January 17, 2023. R4's 14-day reassessment completed February 2, 2023 (17 days after start of services). R7 R7 was admitted January 19, 2022, and had diagnoses to include vascular dementia and cerebrovascular disease (affects blood flow and circulation). R7's service plan dated July 21, 2023, indicated R7 received services to include assistance with meals, housekeeping, laundry, toileting, "extensive am assist," "extensive pm assist," and medication management. R7's record included an initial assessment completed January 19, 2022. R7's record lacked a 14-day comprehensive nursing assessment. On August 28, 2023, at 10:25 a.m., during entrance conference, regional director of clinical services (RDCO)-B stated the RNs complete the nursing assessments in the electronic medical record (EMR). Nurses complete an assessment prior to move in, at admission, within 14 days of admission, every 90 days, and as needed for change in condition. On August 28, 2023, at 3:10 p.m. Licensed	01620		

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	36884	A. BUILDING: _____ B. WING _____	09/05/2023

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01620	Continued From page 15 assisted living director (LALD)-A stated licensee continued with audits for assessments as they have had issues with being timely. LALD-A stated she will look at the EMR queue weekly to make sure everyone knows what is coming up and needs to be completed. LALD-A stated she can see that R4's 14-day assessment was done late. On August 29, 2023, at 8:10 a.m., RDCO-B stated licensee has a queue in the EMR that shows the due dates for assessments. RDCO-B confirmed R4's 14-day assessment was late and did not know why it was not done timely. On August 29, 2023, at 10:55 a.m., RDCO-B stated R2's reassessment was completed greater than 14 days after R2 started receiving services. In addition, RDCO-B indicated R7's record did not contain a 14-day nursing assessment. RN-B further stated, he was unsure why the 14-day nursing assessment for R7 was missed and stated it must have been overlooked. The licensee's MN AL Nursing Assessment Policy updated May 3, 2022, included "7. An RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Initial Assessment; b. 14-day assessment, completed up to 14-days after start of services and will include; i. An evaluation of the resident's medication management services and the resident's medications and complete a medication management plan if the organization provides services related to the resident's medications; ii. An evaluation of the resident's treatments, if any and complete the treatment and therapy management plan if the organization provides	01620		

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01620	Continued From page 16 services related to the resident's treatments; and iii. Communication of any new problems or concerns to the resident's physician or health care providers." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 17 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content 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) 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: R5's service plan signed August 15, 2023, indicated R5 received services including care medication monitoring, management and administration, bathroom assistance, extensive morning and evening cares, homemaking, redirection, weekly laundry, shower, compression socks, unlimited escorts, and vital signs as needed. R5's progress notes from July 19, 2023, at 12:11 p.m., indicated R5 signed on to in home hospice services. R5's hospice plan of care dated July 28, 2023, indicated the following hospice services provided one registered nurse (RN) visit every seven days, twice monthly visit for medical social worker (MSW), and one home health aide (HHA) visit every seven days, Chaplin (CH) to evaluate for	01650		

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01650	Continued From page 18 frequency. On August 29, 2023, at 7:55 a.m., surveyor observed unlicensed personnel (ULP)-H providing morning cares and a medication pass to R5 in her room. R5 was agitated and communicated with nonsensical talk. ULP-H was slow with giving the medications to allow R5 to process everything before moving to the next step. R5's record lacked an updated service plan including hospice services. On August 29, 2023, at 10:58 a.m., regional director of clinical services (RDCO)-B stated licensee does an assessment when a resident has gone on hospice services, but they do not add this to the service plan. No other facilities that have been under his direction add in home hospice services to their plan of care. RDCO-B stated licensee would dispute this finding as they have never received a tag for this in the past. On August 29, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A stated licensee had not ever completed service plan updates after hospice admissions if residents, and they were not aware they should. LALD-A further stated they would not feel comfortable adding Hospice services to the service plan as they have that as part of their contract. LALD-A stated she would reach out to licensee attorney to see if they can come up with a better place to add Hospice services. LALD-A stated if we looked at all the charts with residents on hospice, we would not find any had added in home hospice services to the service plan. The licensee's service plan policy dated August 1,	01650		

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01650	Continued From page 19 2021, indicated, "All assisted living residents will have an up-to-date plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. -Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be emailed confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. -Service plans are reviewed and revised as needed based upon on-going resident assessment. -Service plans will include: -A description of the services provided -Fees for services -Frequency of each service according to resident assessment and resident preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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	02040		

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02040	Continued From page 20 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop complete content of the required memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a 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 residents). The findings include: On September 1, 2023, at approximately 9:15 a.m., survey staff received and reviewed the undated, Kaiser Permanente, Hazard Vulnerability Assessment Tool for review. On September 1, 2023, approximately from 10:30 a.m. to 1:15 p.m., survey staff toured the facility with the regional engineering manager (REM)-H and the environmental services director (ESD)-I. At approximately 2:00 p.m., document review and interview with the licensed assisted living director (LALD)-A, the REM-H and the ESD-I indicated the facility's safety risk assessment and mitigation plan was incomplete and lacked memory care	02040		

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02040	Continued From page 21 site-specific mitigations in the plan to protect the memory care residents from harm. The finding was evident as survey staff received the revised plan documentation with new assessments and mitigations specific to protect the memory care residents from harm from the LALD-A during the interview. The LALD-A asked survey staff for review and feedback on their recently revised plan. On September 1, 2023, at approximately 2:15 p.m., during the exit interview, survey staff discussed the findings and explained to the LALD-A that all potential memory care site-specific safety risks or vulnerabilities including candle jars, resident access to chemicals/detergent, comprised windows, and any sharp objects must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The LALD-A acknowledged and agreed with the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *08/30/23*
Time: 14:03:20
Report: 1023231171

Food and Beverage Establishment Inspection Report

Location:
Lexington Landing
900 Old Lexington Avenue
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0038918
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516956400
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

OBSERVED CUPS USED TO DISPENSE CHEESE FROM PREP COOLER. USE SCOOPS WITH HANDLES.

Comply By: 08/30/23

Surface and Equipment Sanitizers

S&S: = at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

S&S: = at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 179 Degrees Fahrenheit
Location: DISH MACHINE MAIN KITCHEN
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: DISH MACHINE BISTRO
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: DRAWER COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER #1
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CAKE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: Yes

Process/Item: Cold Hold/CUT MELON
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

Process/Item: Cold Hold/FRUIT
Temperature: 39 Degrees Fahrenheit - Location: REACH IN COOLER BISTRO
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 187 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS COMMERCIAL EQUIPMENT IN A MAIN KITCHEN AREA, BISTRO AREA, AND MEMORY CARE AREA. FOOD SERVICE IS PROVIDED BY CARE FACILITY STAFF.

FOODS SUCH AS PRE-COOKED CHICKEN, ROASTS, AND ROP SOUPS ARE PREPARED AT THE PRES HOMES COMMISSARY KITCHEN AND DELIVERED FROZEN.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

Type: Full
Date: *08/30/23*
Time: 14:03:20
Report: 1023231171
Lexington Landing

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 1023231171 of 08/30/23.

Certified Food Protection Manager: JAMES KLEIN

Certification Number: 2391 Expires: 06/25/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JAMES KLEIN
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us