



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

June 13, 2024

Licensee  
Talamore Senior Living Woodbury  
289 Karen Drive  
Woodbury, MN 55129

RE: Project Number(s) SL39372015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at [Health.assistedliving@state.mn.us](mailto:Health.assistedliving@state.mn.us).

The Minnesota Department of Health completed an initial survey on May 14, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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 Department of Health documents state 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00**

**The total amount you are assessed is \$500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

Per 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 residents/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 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.

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 MDH 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>.

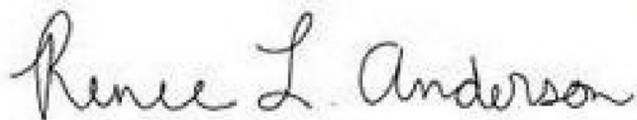
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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](mailto: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 Anderson, Supervisor  
State Evaluation Team  
Email: [Renee.L.Anderson@state.mn.us](mailto:Renee.L.Anderson@state.mn.us)  
Telephone: 651-201-5871 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TALAMORE SENIOR LIVING WOODBURY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>289 KAREN DRIVE WOODBURY, MN 55129</b>
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(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
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0 000	<p><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> SL39372015-0</p> <p>On May 13, 2024, through May 14, 2024, 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 seventy-one residents, all of whom received services under the provider's Assisted Living with Dementia Care license.</p>	0 000	<p>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 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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 510 SS=F	<p><b>144G.41 Subd. 3 Infection control program</b></p> <p>(a) All assisted living facilities must establish and maintain an infection control program that</p>	0 510		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 510	<p>Continued From page 1</p> <p>complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff and visitors.</p> <p>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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p><b>SHARED MEDICAL EQUIPMENT</b></p> <p>On May 14, 2024, at 6:51 a.m., the surveyor observed licensed practical nurse (LPN)-K check R6's blood pressure. LPN-K removed the cuff from the resident's right arm, placed the blood pressure device into a small red carry bag, and returned to the nurse station area with the small</p>	0 510		

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0 510	<p>Continued From page 2</p> <p>red carry bag. LPN-K did not disinfect the blood pressure device after using it on R6.</p> <p>On May 14, 2024, at 6:55 a.m., LPN-K stated the blood pressure machine was used for all residents and all shared medical equipment should be wiped down after use. LPN-K stated, "I guess I forgot".</p> <p>On May 14, 2024, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-L check R5's blood pressure. ULP-L removed the cuff from the resident's right arm and returned the blood pressure device to the medication cart. ULP-L did not disinfect the blood pressure device after using it on R5.</p> <p>On May 14, 2024, at 7:46 a.m., ULP-L stated shared medical equipment should be cleaned immediately after it was used, and forgot to perform the disinfection.</p> <p>On May 14, 2024, at 9:51 a.m., clinical nurse supervisor (CNS)-C stated shared medical equipment should be disinfected after each use. CNS-C stated ULP-L reported the stated situation to her and apologized.</p> <p>The licensee's undated Disinfecting Reusable Equipment and Environmental Surfaces IPC-9.0 policy indicated vital sign equipment should be cleaned after each use.</p> <p>The CDC Disinfection of Healthcare Equipment guidance, dated May 24, 2019, indicated it was a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection</p>	0 510		

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0 510	Continued From page 3  agency (EPA) registered low or intermediate level disinfectant.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment  (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.  This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the potential to affect all staff, residents, and visitors.  This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 800		

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0 800	<p>Continued From page 4</p> <p>a large portion or all of the residents).</p> <p>Findings include:</p> <p>On May 14, 2024, at 11:00 a.m., survey staff toured the facility with regional director of maintenance (RDM)-M. It was observed that the trash chute doors in the following locations did not shut and latch on their own:</p> <ol style="list-style-type: none"> <li>1. First-floor service corridor, both the trash and recycling chute doors did not close on their own.</li> <li>2. First-floor trash room trash chute door did not close on its own.</li> <li>3. Second-floor trash room recycling chute door did not close on its own.</li> <li>4. Third-floor trash room trash chute door did not close on its own.</li> <li>5. Fourth-floor trash room trash chute door did not close on its own.</li> </ol> <p>All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system.</p> <p>It was observed that the smoking area outside the service corridor entrance doors had a metal bucket that was used by the staff as an ashtray and garbage. The facility did not have a non-combustible ashtray in the area. Survey staff explained to the licensee that a fire-rated ashtray should be provided for staff use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them into the bucket where trash was also discarded.</p> <p>During an interview on May 14, 2024, at 2:00 p.m., RDM-M stated he understood the above-listed deficiencies.</p>	0 800		

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0 800	Continued From page 5  TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> <li>(1) location and number of resident sleeping rooms;</li> <li>(2) employee actions to be taken in the event of a fire or similar emergency;</li> <li>(3) fire protection procedures necessary for residents; and</li> <li>(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.</li> </ul> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p>	0 810		

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0 810	<p>Continued From page 6</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On May 14, 2024, licensed assisted living director (LALD)-A and regional director (RD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b> The licensee's FSEP, titled "Fire Emergency", dated 03/11/2024, failed to include the following:</p> <p>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) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but failed to include procedures for how staff are to complete each</p>	0 810		
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0 810	<p>Continued From page 7</p> <p>step.</p> <p>During an interview on May 14, 2024, at 2:00 p.m., LALD-A stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance.</p> <p><b>TRAINING</b> Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A provided documentation showing staff received training once, but was unable to provide documentation showing any additional training provided or training scheduled for a future date for staff on the fire safety and evacuation plan.</p> <p>During an interview on May 14, 2024, at 2:00 p.m., LALD-A and RD-D stated they were completing training for the staff at the same time as the evacuation drills. Survey staff explained to LALD-A that training must be completed separately from the evacuation drills to ensure all staff members are receiving the minimum amount of training required by statute. LALD-A and RD-D stated they understood the areas of their training that were insufficient and would work on bringing them into compliance.</p> <p><b>DRILLS</b> Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated evacuation drills were completed on 02/06/2024, 04/09/2024, and 04/17/2024. No further documentation was provided.</p> <p>During an interview on May 14, 2024, at 2:00 p.m., RD-D stated there were no additional</p>	0 810		

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0 810	Continued From page 8  documented drills for the facility and verified this deficient condition.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=D	<p><b>144G.71 Subd. 19 Storage of medications</b></p> <p>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of five residents (R4).</p> <p>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).</p> <p>The findings include:</p> <p>R4's diagnoses included Alzheimer's disease, major depressive disorder, fracture of the lower left leg, left ankle fracture, insomnia, hypertension, hemiplegia (paralysis of one side of</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TALAMORE SENIOR LIVING WOODBURY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>289 KAREN DRIVE WOODBURY, MN 55129</b>
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(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
01880	<p>Continued From page 9</p> <p>the body), hypercholesterolemia (high cholesterol), low back pain, and gastro-esophageal reflux disease (GERD).</p> <p>R4's signed Service Plan Agreement with an effective date of April 17, 2024, indicated R4 received services including assistance with medication administration.</p> <p>On May 14, 2024, at 6:43 a.m., the surveyor observed the following on R4's nightstand; Xylimelts Dry Mouth, Numb520 5 percent (%) Lidocaine topical anorectal cream, and CeraVe Moisturizing cream.</p> <p>R4's medication administration record (MAR) dated May 1, 2024, through May 13, 2024 indicated the resident was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>-ibuprofen 400 milligram (mg) 1 tablet three times daily;</li> <li>-oyster Shell Calcium (OS-CAL 500 tablet) 1 tablet by mouth twice daily;</li> <li>-acetaminophen extra strength 500 mg 2 tablets four times daily;</li> <li>-alendronate 70 mg 1 tablet once weekly on Saturday;</li> <li>-arthritis pain 1% apply 4 grams (gm) to right knee twice daily;</li> <li>-aspirin 81 mg enteric coat (EC) 1 tablet daily;</li> <li>-donepezil 10mg 1 tablet daily;</li> <li>-duloxetine 60 mg 1 tablet daily;</li> <li>-famotidine 20 mg 1 tablet daily;</li> <li>-gabapentin 300 mg 3 capsules daily;</li> <li>-ipratropium 0.06 % 2 sprays in both nostrils three times daily;</li> <li>-memantine 10 mg 2 tablets daily;</li> <li>-Myrbetriq 25 mg extended release (ER) 1 tablet daily;</li> <li>-turmeric 500 mg 2 capsules daily;</li> </ul>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TALAMORE SENIOR LIVING WOODBURY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>289 KAREN DRIVE WOODBURY, MN 55129</b>
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(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
01880	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>-quetiapine 25 mg 1 tablet three times daily;</li> <li>-vitamin D3 50 micrograms (mcg) 1 capsule daily;</li> <li>-preservation areds 1 tablet daily;</li> <li>-vitamin B-12 5000 mcg 1 tablet daily;</li> <li>-melatonin 10 mg 1 capsule at bedtime;</li> <li>-Asperflex lidocaine 4% apply to affected area (lower back) as needed; and</li> <li>-docusate senna 50 8.6 mg 1 tablet every 12 hours as needed.</li> </ul> <p>The MAR lacked the medications located in R4's room.</p> <p>R4's assessment dated April 30, 2024, included the Medication Management Plan. The Medication Management Plan indicated the resident would not self-administer medications and resident medications would be secured in a locked medication cart for staff to administer medications.</p> <p>On May 14, 2024, at 12:01 p.m., clinical nurse supervisor (CNS)-C stated resident family's were educated to bring OTC medications to the registered nurse (RN) and not to leave with residents. The RN was responsible for obtaining a prescription order from the medical provider for administration to the resident. CNS-C stated staff were expected to bring OTC medications to the nurse, "some staff are better than others". CNS-C stated the OTC medications should be removed as the RN did not assess the resident was safe to store and administer OTC medications.</p> <p>On May 14, 2024, at 12:19 p.m., unlicensed personnel (ULP)-L stated medications should not be left in resident rooms and should be returned to the RN.</p> <p>The licensee's undated Storage of Medication MED 11.0 policy indicated the RN would conduct</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39372</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TALAMORE SENIOR LIVING WOODBURY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>289 KAREN DRIVE WOODBURY, MN 55129</b>
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(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
01880	<p>Continued From page 11</p> <p>an assessment and develop the resident Individualized Medication Management Plan to determine how medications should be stored and if the [licensee] should administer the medications to the resident.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01880		



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

Type: Full  
 Date: 05/13/24  
 Time: 13:07:09  
 Report: 1023241108

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Talamore Senior Living Woodbur  
 289 Karen Drive  
 Woodbury, MN55125  
 Washington County, 82

**Establishment Info:**

ID #: 0042409  
 Risk:  
 Announced Inspection: No

**License Categories:**

Expires on: 12/31/24

**Operator:**

Phone #: 6517647295  
 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.

No NEW orders were issued during this inspection.

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

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

FOOD SERVICE IS PROVIDED BY A THIRD PARTY VENDOR. INSPECTOR VERIFIED THE THIRD PARTY VENDOR HAS AN ACTIVE LICENSE WITH THE LOCAL DELEGATED AGENCY: WASHINGTON COUNTY DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT LIC #751133

**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 1023241108 of 05/13/24.

Certified Food Protection Manager: MARK SAMARASINGHE

Certification Number: 59149 Expires: 02/09/26

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

BREANNA BRUCE  
 PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson  
 Public Health Sanitarian  
 Freeman Building  
 651-201-4259

Type: Full  
Date: 05/13/24  
Time: 13:07:09  
Report: 1023241108  
Talamore Senior Living Woodbur

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# Food and Beverage Establishment Inspection Report

*Gregory T Nelson*

greg.nelson@state.mn.us