Electronically Delivered

July 31, 2023

Licensee
Oak Ridge Assisted Living Of Hastings
1128 Bahls Drive
Hastings, MN 55033

RE: Project Number(s) SL30750015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 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.

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 and enforcement actions 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).

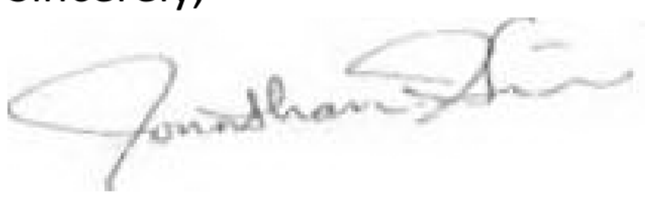
Please address your cover letter for reconsideration requests to:

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30750	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE ASST LVG OF HASTINGS	1128 BAHLS DRIVE HASTINGS, MN 55033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30750015 On July 10, 2023, through July 12, 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 60 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
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	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 2 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a history and symptom screening for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The facility TB risk assessment dated September 9, 2022, indicated the facility was a low risk setting for TB transmission. ULP-E was hired November 1, 2021, and provided direct cares for residents of the facility. ULP-E's employee file lacked documentation of a	0 660		

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0 660	Continued From page 3 TB history and symptom screening. During an interview on July 12, 2023, at 10:40 a.m., registered nurse (RN)-G stated the history and symptom screening was not in the employee's file, and she was unable to locate it. The Minnesota Department of Health's Tuberculosis (TB) Screening & Education Requirements for Assisted Living Facilities and Home Care Providers guide, dated February 3, 2022, indicated baseline screening was required at the time of hire for all health care personnel, which included assessing TB history. The licensee's Tuberculosis Screening policy dated December 22, 2021, indicated staff would be screened and tested for TB upon hire and the results would be kept in the employee's medical file. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 660		
0 800 SS=D	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	0 800		

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0 800	Continued From page 4 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 ability to affect a limited number of staff and 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 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with the Maintenance Supervisor (MS)-J, Licensed Assisted Living Director (LALD)-A, and the Regional Licensed Assisted Living Director (RLALD)-I between approximately 12:00 PM and 4:00 PM on July 12, 2023, it was observed that the fire door to the thrid floor laundry room was missing its door closure device. Education was provided that fire doors must not be held open unless done so by devices that release upon fire alarm activation and that the doors must close and latch to prevent fire from spreading to or from the area. This deficient condition was visually verified by MS-J, LALD-A, and RLALD-I accompanying on the tour. Additionally, in the memory care's kitchen, utensils were unsecured in a drawer and some chemicals were kept in an unsecured cabinet. These items are required to be in secure areas	0 800		

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0 800	Continued From page 5 within the memory care to prevent the occurrence of potential injury to those in the facility. This deficient condition was visually verified by MS-J, LALD-A, and RLALD-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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 the steps of the medication administration process were followed for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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01760	Continued From page 6 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: R3's diagnosis included dementia. R3's service plan dated June 14, 2023, indicated R2 received services to include medication administration. R3's prescriber orders dated June 13, 2023, included orders for Azelastine HCL 0.05% eye drops (for itchy eyes associated with allergies) and Propylene Glycol/PF 0.6% eye drops (for dry eyes). On July 11, 2023, at 7:24 a.m. unlicensed personnel (ULP)-E was observed to administer one drop of Azelastine 0.05% eye medication into each of R3's eyes. At 7:25 a.m. (less than five minutes between eye medication administration), ULP-E administered one drop of Propylene Glycol/PF 0.6% into each of R3's eyes. On July 11, 2023, at 1:00 p.m., ULP-E stated she was trained in eye drop administration by the licensee. ULP-E indicated initial medication administration training included eye drops and skills testing and is completed upon hire and annually. ULP-E's skills competency, dated December 14, 2021, indicated ULP-E completed competency on the eye drops procedure which included waiting five minutes between drops when administering different eye medications. On July 11, 2023, at 3:00 p.m., registered nurse	01760		

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01760	Continued From page 7 (RN)-G stated unlicensed personnel should wait five minutes between administering eye medications. RN-G further stated the licensee's Medications and Treatments policy was wrong and should indicate five minutes between eye drops. The licensee's Medications and Treatments policy dated March 28, 2023, indicated there should be one to two minutes between eye drops if more than one kind of eye drop was being used. The American Academy of Ophthalmology guidelines on eye drop administration, dated May 5, 2023, indicated when using more than one type of eye medication at the same time: wait three to five minutes between each administration. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 8 person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents' legal and designated representative at the time of move-in. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	02110		

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02110	Continued From page 9 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an Assisted Living with Dementia Care license effective August 1, 2022. On July 11, 2023, at 3:05 p.m., housing coordinator (HC)-H stated the residents were not provided a copy of the required policies and was unaware of the requirement. The licensee's Assisted Living with Dementia Care Additional Required Policies policy, dated December 22, 2021, verified the Assisted Living with Dementia Care license required policies "must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 10 Based on observation, and interview, the licensee failed to ensure that oxygen cylinders were properly stored for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: One July 11, 2023, at 8:30 a.m., the surveyor observed four oxygen cylinders in R6's apartment. One cylinder was secure in the refill compartment of the oxygen concentrator. Three cylinders were observed to be unsecured standing upright to the left of the oxygen concentrator. On July 11, 2023, at 8:35 a.m., unlicensed personnel (ULP)-D stated she were provided training by the nurse on how to check for oxygen in the cylinders, how to refill the cylinders, and to store the cylinders in an upright position. On July 11, 2023, at 3:00 p.m., registered nurse (RN)-G stated oxygen cylinders should be secured in a cart to prevent them from falling over. The licensee's Oxygen policy dated March 28, 2023, lacked documentation for secured storage of oxygen cylinders in chains or racks.	02310		

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02310	Continued From page 11 The oxygen supply company's Welcome Guide, page 23,dated 2022, indicated oxygen cylinders should be lying flat unless secured in a stand or cart. The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16,2020, states, "cylinders must be secured (chains or racks) to prevent them from falling over." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/10/23*
Time: 11:30:32
Report: 1036231173

Food and Beverage Establishment Inspection Report

Location:

Oak Ridge Asst Lvg Of Hastings
1128 Bahls Drive
Hastings, MN55033
Dakota County, 19

Establishment Info:

ID #: 0038252
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514380418
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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO TEMPERATURE DEVICE ON SITE FOR MEASURING UTENSIL SURFACE TEMPERATURE OF HOT WATER DISH MACHINE. PROVIDE AND MAINTAIN.

Comply By: 07/24/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

OBSERVED SIGNIFICANT DUST ACCUMULATION ON THE AIR VENT ABOVE THE PREP TABLE NEAR THE STOVE. CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 07/24/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: < at 163.3 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

Type: Full
Date: *07/10/23*
Time: 11:30:32
Report: 1036231173
Oak Ridge Asst Lvg Of Hastings

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cook Temp/LASAGNA
Temperature: 192 Degrees Fahrenheit - Location: JUST OUT OF OVEN
Violation Issued: No

Process/Item: Cold Holding/SLICE TOMATO
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/CHX SALAD
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 5 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 35 Degrees Fahrenheit - Location: BEVERAGE AIR REACH IN
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JOLENE BERTELSEN. INSPECTION CONDUCTED IN PRESENCE OF TAMMY MAYER, THE KITCHEN MANAGER. ALL VIOLATIONS WERE DISCUSSED WITH KITCHEN MANAGER AND HRD EVALUATORS DURING INSPECTION.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH KITCHEN MANAGER:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036231173 of 07/10/23.

Certified Food Protection Manager: Tammy L. Mayer

Certification Number: FM75754 Expires: 10/18/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tammy Mayer
Kitchen Manager

Signed: _____
Jeff Johanson