Electronically Delivered

March 27, 2023

Licensee
Woodstone Senior Living
1025 Dale Street Southwest
Hutchinson, MN 55350

RE: Project Number(s) SL29911015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 evaluation of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 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 licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

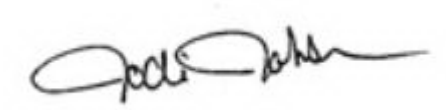
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 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
	29911	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#29690015 On February 21, 2023, through February 23, 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 39 residents, all whom received services under the provider's Assisted Living/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 issued 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	0 480		

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0 480	Continued From page 1 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 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 Februatry 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=C	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 2 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C had a start date of December 9, 2021.	0 650		

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0 650	Continued From page 3 ULP-D had a start date of September 13, 2021. ULP-C and ULP-D's records lacked evidence of the following required content: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision On February 23, 2023, at 10:00 a.m. licensed assisted living director (LALD)-A confirmed ULP-C and ULP-D's employee files did not include the above required content. LALD-A further confirmed it was not their practice to include a job description in any of the employee files. The licensee's undated Personnel Files policy indicated: 2. The personnel record for each person will include: j. Current job description, which includes qualifications, responsibilities and identification of staff person providing supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 4 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all 43 residents receiving services under the assisted living with dementia care license. 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 the residents). The findings include:	0 680		

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0 680	Continued From page 5 The licensee's Emergency Preparedness Procedures binder last reviewed August 2, 2022, lacked the following required content: -policy and procedure for tracking staff; -policy and procedure for roles under a 1135 waiver declared by Secretary - emergency prep testing requirements. On February 23, 2023, at 1:09 p.m. licensed assistant living director (LALD)-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z which included the above content. The licensee's undated Emergency Preparedness Manual policy indicated: 2. The Licensed Assisted Living Director will review the manual annually and as needed to ensure that it is current and up to date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 6 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R2). 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: R2's diagnoses included late onset Alzheimer's dementia with behavioral disturbance, history of stroke, hypertension (high blood pressure), and chronic kidney disease. R2's After Visit Summary dated January 9, 2023, indicated the resident was evaluated for cellulitis (a common, potentially serious bacterial skin infection) of the left lower extremity. Physician	01640		

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01640	Continued From page 7 orders indicated to continue with daily dressing changes including non-stick dressing, gauze and ace wrap to help with swelling. R2's change of condition assessment dated January 10, 2023, indicated the resident had three open areas on his left lower leg/ankle area. 1) Inner ankle-approximately 4.3 cm (centimeters) x (by) 1.8 cm (top layer off and minimal serous drainage present); 2) Front ankle - approximately 4.5 cm x 4.0 cm (top layer of skin off; scant serous drainage present); 3) Outer ankle-approximately 4.3 cm x 1.6 cm (top layer of skin off; scant serous drainage). Wound treatment plan indicated daily dressing changes - covered with non-stick dressings, gauze and ACE wraps to help with swelling. On February 22, 2023, at 8:45 a.m. unlicensed personnel (ULP)-D was observed performing wound care with dressing change to R2's lower left leg. R2's Service Plan Agreement effective January 10, 2023, did not include daily wound care and dressing change to R2's left lower leg. On February 23, 2023, at 10:15 a.m. director of health services (DHS)-B confirmed R2's Service Plan did not include the wound care and dressing change treatment though it had been added to the resident's care plan. The licensee's undated Service Plan Agreement policy indicated the Service Plan Agreement will clearly identify: a. A description of the services to be provide, the fees for services, and the frequency of those services, according to the resident's current assessment and resident preferences.	01640		

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01640	Continued From page 8 b. The categories of personnel who will proved each service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin administration via a prefilled insulin pen was according to manufacturer instructions by one of one unlicensed personnel (ULP-C) observed administer insulin. 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	01750		

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01750	Continued From page 9 of staff are involved, or the situation has occurred only occasionally). The findings include: R5's Service Plan effective January 1, 2023, indicated R5 received assistance with medication administration. R5's diagnoses included cognitive impairment and diabetes. R5's prescriber orders dated January 5, 2023, included Novolog FlexPen (an injectable medication for diabetes) inject 10 units at breakfast subcutaneously (under the skin) plus sliding scale order (if necessary per blood sugar reading). R5's sliding scale order indicated if blood glucose less than 149, give 0 units; 150-199, give 1 unit; 200-249, give 2 units; 250-299, give 3 units; 300-349, give 4 units; 349+, give 5 units. On February 22, 2023, at 8:16 a.m. the surveyor observed ULP-C obtain R5's blood sugar which measured 152 mg/dL and ULP-C stated R5 would require one additional unit of insulin according to physician orders. ULP-C obtained R5's Novolog FlexPen, removed the cap, then attached a needle to the port of the pen. ULP-C dialed the pen to 2 units and primed the pen then dialed the pen to the prescribed 11 units. ULP-C did not cleanse the pen port with alcohol prior to attaching the needle to the pen. R1's Service Plan effective January 1, 2023, indicated R1 received assistance with medication administration.	01750		

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01750	Continued From page 10 R1's diagnoses included dementia and diabetes. R1's prescriber orders dated January 19, 2023, included Novolog FlexPen inject 5 units three times a day subcutaneously with meals. On February 22, 2023, at 11:52 a.m. the surveyor observed ULP-C prepare R1's insulin pen for administration. ULP-C obtained R1's Novolog FlexPen, removed the cap, then attached a needle to the port of the pen. ULP-C dialed the pen to 2 units, primed the pen then dialed the pen to the prescribed 5 units. ULP-C did not cleanse the pen port with alcohol prior to attaching the needle to the pen. At 11:58 a.m., ULP-C confirmed she had not cleansed the port of either R1 or R5's insulin pens prior to applying the needle and further stated she never does this when setting up insulin pens. On February 23, 2023, at 10:15 a.m. director of health services (DHS)-B confirmed insulin pens should be administered according to manufacturer's recommendations, and further confirmed the insulin pen port should be cleansed with alcohol prior to applying the needle to the pen. The manufacturer package insert for the Novolog FlexPen revised February 2023, indicated when preparing your Novolog FlexPen: A. Pull off the pen cap. Wipe the rubber stopper with a alcohol swab. B. Attaching the needle - remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability 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 a large portion or all of the residents). Findings include: A record review and interview were conducted on February 24, 2023, between approximately 12:00 p.m. and 12:30 p.m. with Licensed Assisted Living Director (LALD)-A, on the hazard	02040		

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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
02040	Continued From page 12 vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29911	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(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
02170	Continued From page 13 limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R2, R3) who resided in the locked memory care unit. 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 licensee held an assisted living with dementia care license effective August 1, 2022.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29911	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(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
02170	Continued From page 14 R2 R2's diagnoses included late onset Alzheimer's dementia with behavioral disturbance, history of stroke, hypertension (high blood pressure), and chronic kidney disease. R2's Service Plan effective January 10, 2023, indicated R2 received services which included dressing, bathing, grooming, ambulation/exercise assistance, laundry, housekeeping, treatments, behavior monitoring, well-being checks, and medication administration. On February 22, 2023, at 9:22 a.m. unlicensed personnel (ULP)-D was observed administering medications to R2. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R3 R1's diagnoses included dementia, hypertension, urinary incontinence, and history of falls. R3's Service Plan effective January 2, 2023, indicated services included housekeeping, laundry, dressing, grooming, toileting, well-being	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29911	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(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
02170	Continued From page 15 checks, medication administration, behavior monitoring, and assistance with hearing aides. On February 22, 2023, at 8:45 a.m. R3 was observed in the Care Suites II dining room eating breakfast at a table with three other residents. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On February 23, 2023, at 1:16 p.m. office assistant (OA)-F reviewed R2 and R3's medical record and confirmed an activity assessment had not been entered or scanned into the resident's electronic record. OA-F spoke with the community Life Director (CLD)-F who confirmed she had not yet completed the activity assessments for R2 or R3. The licensee's undated, Description of Life Enrichment Programs and How Activities are Implement in Assisted Living with Dementia Care policy indicated: 1. Each resident receiving assisted living services will be evaluated for activities. The evaluation must include: a. Past and current interests	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29911	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(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
02170	Continued From page 16 b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitation e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 2. To further facilitate person-centered care, social history information, information about the person's life history, will be gathered to assist in planning, information gathered may include information such as: a. places lived b. education, work, and military service history c. cultural and religious background d. family and other significant relationships 3. This information will be shared with staff as they are oriented to the individual. 4. An individualized activity plan will be develop[ed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *02/21/23*
Time: 12:00:00
Report: 1033231028

Food and Beverage Establishment Inspection Report

Location:
Woodstone Senior Living
1025 Dale Street SW
Hutchinson, MN55350
Mc Leod County, 43

Establishment Info:
ID #: 0029667
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Bear Paw Enterprises

Phone #: 3202348917
ID #: 39437

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.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Facility is using non-pasteurized eggs to hot hold scrambled eggs.

Comply By: 02/21/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have a test kit to measure quaternary ammonium concentration.

Comply By: 03/07/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Employees are pouring excess coffee down he hand washing sink.

Comply By: 02/21/23

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

Open employee beverages stored above food preparation area.

Comply By: 02/21/23

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

Soiled cloths are stored on the preparation counters.

Comply By: 02/21/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

Ice machine has visible soil accumulation inside.

Comply By: 02/21/23

Surface and Equipment Sanitizers

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Type: Full
Date: *02/21/23*
Time: 12:00:00
Report: 1033231028
Woodstone Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Shredded Beef-Low Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Milk Cooler
Violation Issued: No

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: Ham-Hot Line
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Baked Potatoes-Hot Line
Violation Issued: No

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

Follow code reference 4626.0447 sub parts B and F, for pasteurized eggs requirement.

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 1033231028 of 02/21/23.

Certified Food Protection Manager: Jacob O Work

Certification Number: FM52185 Expires: 10/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jacob O Work

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033231028

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	4	Date	02/21/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Woodstone Senior Living	Address: 1025 Dale Street SW	City/State: Hutchinson, MN	Zip Code: 55350	Telephone: 3202348917
License/Permit #: 0029667	Permit Holder: Bear Paw Enterprises	Purpose of Inspection: Full	Est Type:	Risk Category: H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Surpervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A N/O — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/24/23

Inspector (Signature)