Electronically Delivered

July 17, 2023

Licensee
Oak Terrace Housing Of Jordan
622 Aberdeen Avenue
Jordan, MN 55352

RE: Project Number(s) SL28513015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 22, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	28513	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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: SL28513015-0 On June 20, 2023, June 22, 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 sixty four 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=C	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 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 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 June 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who	0 550		

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0 550	Continued From page 2 are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified housing only 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 signed the licensee's Assisted Living Contract - Independent on December 6, 2022. R2's record lacked an IAPP developed and implemented by the licensee. On June 20, 2023, at 10:50 a.m., during the	0 550		

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0 550	Continued From page 3 entrance conference, licensed assisted living director (LALD)-A provided the licensee's Current Resident Roster: Comprehensive which listed all residents who resided at the facility. There were three residents who were identified as not receiving services (commonly referred to as independent living or housing only) and were identified by an "X," in the column labeled, "Housing Only, No services." On June 20, 2023, at approximately 1:24 p.m., clinical nurse supervisor (CNS)-B indicated the licensee was not aware an IAPP was required to be developed and implemented for residents who were identified as housing only. CNS-B stated an IAPP was not developed for any of the three identified housing only residents. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, lacked the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 4 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified independent living 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 signed the licensee's Assisted Living Contract - Independent on December 6, 2022. R2's record lacked an IAPP developed and implemented by the licensee. On June 20, 2023, at 10:50 a.m., during the entrance conference, licensed assisted living director (LALD)-A provided the licensee's Current Resident Roster: Comprehensive which listed all residents who resided at the facility. There were three residents who were identified as not receive services (commonly referred to as independent living) and were identified by an "X," in the column labeled, "Housing Only, No services." On June 20, 2023, at approximately 1:24 p.m.,	0 630		

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0 630	Continued From page 5 clinical nurse supervisor (CNS)-B indicated the licensee was not aware an IAPP was required to be developed and implemented for residents who were identified as independent living. CNS-B stated an IAPP was not developed for any of the three identified independent living residents. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, lacked the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	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 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	0 660		

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0 660	Continued From page 6 licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included an updated facility TB risk assessment. This had the potential to affect all current residents, staff 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) 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: The licensee's most current TB facility risk assessment dated June 3, 2022, noted a low risk. The licensee's Facility TB Risk Assessment Worksheet noted their TB risk assessment would be conducted or updated on a yearly basis. On June 20, 2023, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-B confirmed the licensee had not completed their annual TB facility risk assessment as indicated in their policy. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The licensee's Tuberculosis Screening policy revised February 1, 2023, indicated the facility will	0 660		

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0 660	Continued From page 7 maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 800		

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0 800	Continued From page 8 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: On June 22, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Assisted Living Director (LALD)-A and the Director of Maintenance (DOM)-E. During the facility tour, survey staff observed the following items: In the egress stair by resident unit 220 on the second floor, it was observed that the egress door did not close and self-latch when tested. The door is required to automatically close and latch to maintain the fire barrier of the egress stair. In the dining room on the main level, it was observed that the smoke compartment door to the memory care corridor closers had been disabled by removing the closure arm. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the dining room and corridor for safety purposes. In the kitchen and dry food storage on the main level, it was observed that the door was propped open with a rubber wedge, and the door was the fire-rated door. The rubber wedge will prevent the door from closing in the event of a fire. In the activity room on the main level, it was observed that the door did not close and self-latch when tested. The door is required to automatically close and latch to maintain the fire barrier of the room. In the enclosed courtyard, it was observed that the keypad access control was not working and the access to the dining room from the enclosed	0 800		

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0 800	Continued From page 9 courtyard was obstructed. During the facility tour, LALD-A and DOM-E visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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. (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. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide procedures necessary for resident movement, evacuation or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills as required. This 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 a large portion or all of the residents). Findings include: An interview and record review were conducted on June 22, 2023, at approximately 12:30 p.m., with the Assisted Living Director (LALD)-A and the Director of Maintenance (DOM)-E on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety	0 810		

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0 810	Continued From page 11 and evacuation drills for the facility. On a facility tour with the LALD-C on January 6, 2022, between approximately 10:30 a.m. and 11:40 a.m., it was observed that the posted fire safety and evacuation plan on the main level was not accurate depictions of the actual layout of the facility. LALD-A stated that they had an addition of the memory care wing and courtyard, and the evacuation plan has not been updated to show the change. With further review, the posted fire safety plan and evacuation plan did not identify the required elements of fire safety and emergency evacuation. The posted fire safety and evacuation plan did not have the number of resident rooms. This deficient condition was visually verified by LALD-A accompanying the tour. In the restroom by the dining room on the first floor, it was observed that the wall-mounted supply air grille was loose with missing screws. And the sprinkler head was spray painted. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, LALD-A stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, LALD-A stated that the facility provided only one fire safety training and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and	0 810		

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0 810	Continued From page 12 every other month as required by statute. Review of the provided documented drills indicated that the licensee conducted drills every other month but failed to provide two drills on the night shift. LALD-A verified that there were no further drills conducted besides those that were provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950		

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	28513	A. BUILDING: _____ B. WING _____	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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
0 950	Continued From page 13 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the residents the opportunity to identify a designated representative in writing in the contract. In addition, the licensee failed to have residents acknowledge or decline a designated representative in the licensee's contract for three of five residents (R3, R4, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee on October 12, 2021, for assisted living services. R3's unsigned service plan dated May 8, 2023, indicated R3 received services including bathing, fall risk management, assistance with dressing, bed alarm, assistance with personal hygiene and grooming, assistance with toileting, assistance with transferring, emergency evacuation assistance, hospice care, and oxygen therapy. R3's unsigned Resident Contract for Assisted Living dated December 8, 2022, had a section on	0 950		

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0 950	Continued From page 14 the first page titled Designated Representative which was blank, the contract also lacked the required verbatim notice. R4 R4 was admitted to the licensee on December 6, 2021, for assisted living services. R4's unsigned service plan updated December 12, 2022, indicated R4 received services including medication administration, bathing assistance, dressing assistance, cues for grooming and hygiene, toileting help, bed mobility assistance, and positioning/transfer. R4's signed Assisted Living Contract dated December 6, 2021, had a separate page titled Designated Representative with the required verbatim notice which was left blank. R6 R6 was admitted to the licensee on August 7, 2015, under the previous comprehensive license and started receiving assisted living services on August 1, 2021. R6's unsigned Service Plan dated June 19, 2023, indicated R6 received services including medication administration, treatment, bathing assistance, dressing assistance, grooming assistance, toilet assistance, and transfer. R6's Assisted Living Contract dated August 1, 2021, had a separate page titled Designated Representative with the required verbatim notice which was left blank. On June 21, 2023, at 3:00 p.m., licensed assisted living director (LALD)-A stated she agreed they are missing the required acknowledgement or	0 950		

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0 950	Continued From page 15 declination of a designated representative. LALD-A stated the licensee sent an email update for required signature to the addendums needed and DocuSign did not make designation of representative a required field to sign. LALD-A further stated she does not know how many residents this would affected, but it would be a significant number of residents. The licensee's Designated Representative policy dated August 1, 2021, indicated before or at the time of execution of an assisted living contract, the licensee would offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form will be kept in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 16 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-D was supervised by a registered nurse (RN) within 30 days after providing delegated tasks with records reviewed. 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: ULP-D had a hire date of August 23, 2022. On June 21, 2023, at 8:00 a.m. ULP-D was observed to administer morning medications to R5. ULP-D's employee record lacked evidence of direct supervision within 30 days after beginning	01440		

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	28513	A. BUILDING: _____ B. WING _____	06/23/2023

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01440	Continued From page 17 work and first performing delegated tasks. On June 21, 2023, at 1:05 p.m., licensed assisted living director (LALD)-A confirmed the 30-day supervision was not completed. The licensee's Supervision of Staff of Staff - Delegated Services policy dated August 1, 2021, indicated that direct supervision of staff providing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 18 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of five residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 admitted to the licensee on October 12, 2021. R3's diagnoses included chronic kidney disease stage three, pneumonia, acute respiratory failure, severe sepsis, urinary tract infection, unspecified convulsions, anemia, dehydration, dementia with behavioral disturbance, essential hypertension, gastro-esophageal reflux, gout, benign prostatic hyperplasia, weakness, personal history of	01620		

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01620	Continued From page 19 malignant neoplasm of bronchus and lung, and personal history of benign neoplasm of the brain. R3's unsigned service plan dated May 8, 2023, indicated R3 received services including bathing, fall risk management, assistance with dressing, bed alarm, assistance with personal hygiene and grooming, assistance with toileting, assistance with transferring, emergency evacuation assistance, hospice care, and oxygen therapy. R3's record included 90-day nursing assessments completed on December 28, 2022, and April 12, 2023. The last nursing assessment exceeded 90 calendar days by fifteen days. R4 R4 admitted to the licensee on December 6, 2021. R4's diagnoses included type 2 diabetes, history of fall, dementia with psychotic disturbance, gastro-esophageal reflux disease, hypothyroidism, hyperlipidemia, depression, anxiety disorder, obstructive sleep apnea, hypertension, functional dyspepsia, cellulitis of the left toe, acute kidney failure, chronic kidney disease stage 3, overactive bladder, and urinary tract infection. R4's Individual Service Plan Agreement dated March 18, 2023, indicated R4 received services including medication administration, quarterly nursing assessment, housekeeping, laundry, assistance with 2-person transfer, and blood glucose monitoring. In addition, the service plan indicated a nursing assessment of the resident and services were completed every 90 days in person by a RN.	01620		

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01620	Continued From page 20 R4's record included 90-day nursing assessments completed on December 12, 2022, and March 14, 2023. The last nursing assessment exceeded 90 calendar days by two days. On June 22, 2023, at 10:15 a.m., clinical nurse specialist (CNS)-B stated the licensee was aware of time frames for assessments however, she has been unable to complete all assessments before they became overdue because they have a lot to complete. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01620		
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	01640		

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01640	Continued From page 21 about changes to the facility's fee for services 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 the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of four residents (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: On June 21, 2023, at 8:08 a.m. unlicensed personnel (ULP)-D was observed to administer morning medications to R6. R6's Service Plan Agreement dated as printed June 19, 2023, lacked a signature or other	01640		

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01640	Continued From page 22 authentication by the resident or by the facility, documenting agreement on the services to be provided. On June 21, 2023, at 3:11 p.m., licensed assisted living director (LALD)-A stated the service plan had been developed on June 19, 2023, and confirmed it lacked a signature by the resident's representative as required. The licensee's Service Plans policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by Oak Terrace and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		

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

Type: Full
Date: *06/21/23*
Time: 12:00:00
Report: 8041231175

Food and Beverage Establishment Inspection Report

Location:
Oak Terrace Housing Of Jordan
622 Aberdeen Avenue
Jordan, MN55352
Scott County, 70

Establishment Info:
ID #: 0039318
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524925559
ID #:

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

The following orders were issued during this inspection.

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

3-304.14B

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.

WIPING CLOTHS FOUND STORED IN BUCKET WITH SOAPY WATER. STORE WET WIPING CLOTHS IN SANITIZING SOLUTION.

Comply By: 06/21/23

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

THE FOOD PREP SINK FAUCET IS LEAKING. A TECHNICIAN HAS BEEN CONTACTED FOR REPAIR.

Comply By: 06/28/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: spray bottle- kitchen
Violation Issued: No

Quaternary Ammonia: = 0 ppm at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: Yes

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp. sink
Violation Issued: No

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 146 Degrees Fahrenheit - Location: steam table: baked beans
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: reach-in cooler/10: mashed potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 155 Degrees Fahrenheit - Location: oven: pepper
Violation Issued: No

Process/Item: Cooking
Temperature: 167 Degrees Fahrenheit - Location: oven: steak
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: 3 door cooler: tuna salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: 3 door cooler: meatball
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: upright cooler: whipping cream
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: memory care cooler: milk
Violation Issued: No

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

Inspection was completed with Kristin Nelson (Dietary Manager). Rochelle Fox was the lead Health Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen. There is also a refrigerator in memory care used to store beverages.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Date marking

-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population

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 8041231175 of 06/21/23.

Certified Food Protection Manager: Kristi Nelson

Certification Number: fm106182 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kristi Nelson
Dietary Manager

Signed: Sarah Conboy

Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us