DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 6, 2024

Licensee
Oak Ridge Place
6060 Oxboro Avenue North
Oak Park Heights, MN 55082

RE: Project Number(s) SL30722015

Dear Licensee:

On November 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 13, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 18, 2024

Licensee
Oak Ridge Place
6060 Oxboro Avenue North
Oak Park Heights, MN 55082

RE: Project Number(s) SL30722015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE PLACE	6060 OXBORO AVENUE NORTH OAK PARK HEIGHTS, MN 55082

(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: SL30722015-0 On August 12, 2024, through, August 13, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 64 residents; 44 receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	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 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for one of two unlicensed personnel ((ULP)-B). 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 August 13, 2024, at 7:00 a.m., during continuous observations, ULP-B completed hand hygiene with alcohol sanitizer in the hallway outside of a resident's room. ULP-B entered the resident's apartment and obtained the resident's medication lockbox from a storage location. ULP-B placed the lockbox on the kitchen counter and opened the lockbox to access the resident's	0 510		

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0 510	Continued From page 3 medications. ULP-B donned (put on) gloves without completing hand hygiene prior. ULP-B completed the resident's medications administration while wearing gloves. ULP-B returned to the kitchen, doffed (took off) their gloves without completion of hand hygiene, and placed the gloves in a trash receptacle. ULP-B cleaned up, returned medications to the lockbox, returned the lockbox to its storage location, and then left the resident room without completion of hand hygiene. ULP-B completed hand hygiene with alcohol sanitizer outside the next resident's room. ULP-B repeated this process for three (3) different residents. ULP-B was hired on July 24, 2023. ULP-B's record lacked evidence ULP-B completed competency training related to infection control. On August 13, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated ULP-B should have completed hand hygiene immediately before a donning and immediately after doffing gloves. CNS-D stated ULP-B would be trained, and competency testing would be completed for infection control with glove use. CNS-D stated the licensee was not sure why ULP-B had not completed the required infection control training and would audit employee records to identify staff who lacked required training. The licensee's 8.07 Gloves policy dated March 10, 2023, indicated the licensee's expectations for glove use is to completed hand hygiene immediately before donning and immediately after doffing gloves. No further information provided.	0 510		

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms and interconnected smoke alarms throughout the facility. This had the potential to	0 780		

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0 780	Continued From page 5 directly affect all 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 of the residents). Findings include: INSIDE SLEEPING ROOMS On a facility tour on August 12, 2024, from 12:45 p.m. to 4:00 p.m., with maintenance (M)-F, and housing director (HD)-E, it was also observed that smoke alarms were not provided inside the resident sleeping room in dwelling units 120, 210, and 307, there was one smoke alarm in each dwelling unit installed outside in the immediate vicinity of the resident sleeping room. Smoke alarms are required to be installed inside each resident sleeping room and outside in the immediate vicinity of all sleeping rooms within individual dwelling units. During an interview on August 12, 2024, at 1:00 p.m., M-F, and HD-E, stated smoke alarms were not installed inside the sleeping rooms within the individual dwelling units throughout the whole building. INTERCONNECTION On the same tour it was observed that smoke alarms were not installed inside the resident sleeping rooms and interconnected so activation	0 780		

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0 780	Continued From page 6 of one alarm activates all alarms throughout the dwelling unit. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and M-F, and HD-E, verified smoke alarms were not installed inside the sleeping rooms and interconnected with the smoke alarms outside in the immediate vicinity of the sleeping room. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient	0 790		

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0 790	Continued From page 7 condition had the ability to affect all staff, visitors, 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 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: On a facility tour on August 12, 2024, from 12:45 p.m. to 4:00 p.m., with maintenance (M)-F, and housing director (HD)-E, it was observed that the required fire extinguishers throughout the facility had a last service date in June 2023. Required fire extinguishers are required to be serviced annually and inspected for general condition monthly. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on August 12, 2024, at 3:00 p.m., M-F, and HD-E, verified this deficient	0 790		

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0 790	Continued From page 8 finding. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 12, 2024, from 12:45	0 800		

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0 800	Continued From page 9 p.m. to 4:00 p.m., with maintenance (M)-F, and housing director (HD)-E, the surveyor made the following observations of facility hazard or disrepair: The trash chute fire shutter door at the bottom of the trash chute had the fusible link removed that is designed to activate the door to close in the event of a fire in the trash room. The trash chute fire shutter door at the bottom of the trash chute was held open and would not close. The trash chute fire shutter door is required to be maintained as designed and automatically close in the event of a fire in the trash room to prevent the spread of fire into the trash chute. The trash chute fire door did not self-close or latch in the first floor first floor laundry room. The trash chute fire door was not provided with a closer in order for the door to automatically close in the third-floor laundry room. The trash chute fire doors are required to close and latch automatically as designed in order to prevent the spread of fire in the trash chute. The service documentation for the commercial kitchen hood fire suppression system last date of service was in 2019. Commercial kitchen hood fire suppression systems are required to be serviced annually in accordance with current Minnesota Fire Code. The door closers were removed from the fire-resistant rated doors in resident sleeping rooms 120, 210, 307, and the trash termination room doors in the parking garage. During an interview on August 12, 2024, at 1:15 p.m., M-F, and HD-E, stated the closers were removed on all fire-resistant rated resident sleeping room doors and several other fire-resistant rated doors	0 800		

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0 800	Continued From page 10 throughout the facility. Fire-resistant rated doors are required to be maintained with the closers installed as designed and approved at the time of construction approval according to current Minnesota Fire Code. The fire-resistant rated door leading into the elevator lobby from the underground parking would not positively latch because the latch hardware was stuck inside the door. The fire-resistant rated door leading into the boiler equipment room would not automatically close and latch. Fire-resistant rated doors are required to be maintained to automatically close and latch as designed and installed according to current Minnesota Fire Code. There were kick down door hold open devices installed on several fire-resistant rated doors throughout the facility. Fire resistant rated doors are required to be maintained automatic closing as designed and installed at the time of construction approval. Hold open devices are required to release upon activation of the building fire alarm, fire sprinkler system, or loss of power in accordance with current Minnesota Fire Code. There was a hole through the inside drywall membrane of the fire-resistant rated wall behind the clothes washing machine in the second-floor laundry room and in the room previously used as individual resident storage on second floor. Fire-resistant rated wall drywall membranes are required to be maintained as designed and installed according to current Minnesota Fire Code. There was a hole through the floor membrane of the fire-resistant rated floor assembly in the room	0 800		

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0 800	Continued From page 11 previously used as individual resident storage on second floor. There was a hinge missing on the fire-resistant rated door leading into the maintenance shop in the parking garage. The hinges were loose and needed repair on the fire-resistant rated doors leading into the trash termination room in the parking garage. The required exterior exit door near parking space 49 in the parking garage was damaged and pulled apart at the bottom of the door caused by weather deterioration and rubbing on the exterior ground surface when opened. The same exterior exit door was not able to be opened fully because it was hitting the ground surface on the bottom of the door. There was an extension cord used to power an air conditioning unit and a microwave in the commercial kitchen. Heating and cooling appliances are required to be plugged directly into a wall outlet according to manufactures installation instructions and current Minnesota Fire Code. There were two freezers daisy chained to two different electrical splitters in the storage room in the parking garage. Electric cooling appliances are required to be plugged directly to a wall outlet and not daisy chained with extension cords according to current Minnesota Fire Code. There was an open electrical box exposing electrical wires near the fire sprinkler riser in the parking garage. There was demolition work completed in the	0 800		

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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
0 800	Continued From page 12 room previously used as individual resident storage on second floor. During an interview on August 12, 2024, at 3:15 p.m., M-F, and HD-E, stated they were planning to use the room for a different purpose in the future. All proposed construction work and change of use of spaces in the building is required to be submitted to Minnesota Department of Health and local building code department for approval. The exhaust system for the garage is in disrepair and not working as designed and installed at the time of construction approval. The damper motor on the exhaust intake vents near parking space 50 in the parking garage was coming off the wall and had damaged electrical conduit exposing electrical wires. There was a broken electrical switch plate in the storage room inside the commercial kitchen. The exterior brick veneer was crumbling and cracking in several areas around the exterior of the building. There was a water leak on the water heater bypass in the boiler equipment room in the parking garage. During a facility tour on August 12, 2024, at 3:45 p.m., M-F, and HD-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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	30722	A. BUILDING: _____ B. WING _____	08/13/2024

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0 810	Continued From page 13 (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 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 the fire safety and evacuation plan with required content, make the plan readily available, provide required	0 810		

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0 810	Continued From page 14 training and drills. This had the potential to directly affect all 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 potential to affect a large portion or all of the residents). The findings include: During observation on August 12, 2024, at 12:15 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in a locked staff office and not available to all occupants including residents, staff, and visitors. On August 12, 2024, at 12:20 p.m., housing director (HD)-E, and licensed assisted living director (LALD)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees specific to the FSEP for this facility, the documentation provided for employee training was for general fire safety and not specific to the facility. Record review of the available documentation indicated the licensee failed to provided	0 810		

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0 810	Continued From page 15 evacuation training to residents at least once per year as evident by not providing documentation the FSEP training for residents was completed as required. During an interview on August 12, 2024, at 12:40 p.m., HD-E, and LALD-C, stated the employee FSEP training was general fire safety awareness and not specific to the facility and based on FSEP procedures. During the same interview HD-E, and LALD-C, stated documentation was not available for resident training based on the facility FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly	0 820		

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0 820	Continued From page 16 affect more than a limited number of 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 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). Findings include: On a facility tour on August 12, 2024, from 12:45 p.m. to 4:00 p.m., with maintenance (M)-F, and housing director (HD)-E, the following distinct hazards were observed: There was a barrel bolt slide lock installed in addition to the panic hardware on the required marked exterior exit door in the parking garage near parking space 49. Required marked exit doors are required to be maintained as designed and installed and release to open in one operation with the panic hardware in accordance with current Minnesota Fire Code. These deficient conditions were visually verified by M-F, and HD-E, accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:	01330		

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01330	Continued From page 17 (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired November 13,	01330		

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01330	Continued From page 18 2018, and July 24, 2023, respectively. ULP-A's Minnesota Nursing Assistant Registry Verification of Registration dated March 25, 2022, indicated ULP-A's nursing assistant certification (commonly referred to as a certified nursing assistant (CNA)) expired on May 6, 2022. ULP-A's record lacked evidence ULP-A was trained and found competent in the required areas after expiration of CNA. ULP-B's record lacked evidence ULP-B was trained and found competent in the required areas. On August 13, 2023, at 8:30 a.m., licensed assisted living director (LALD)-C stated ULP-A had allowed their CNA to expire, and licensee had not completed retraining in the required areas when the certification expired. LALD-C stated ULP-B was not trained or found competent in any of the required areas during orientation or prior to the provision of services. LALD-C stated the licensee should have completed the required training and competency training to both ULPs. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2023, indicated ULPs would be trained and found competent in the required areas prior to the provision of services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		

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01530	Continued From page 19	01530		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required eight (8) hours of dementia care training prior to providing cares to residents for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 20 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-B was hired on July 24, 2023. ULP-B's My Transcript dated October 19, 2023, identified by licensed assisted living director (LALD)-C as ULP-B's complete training record, indicated ULP-B completed four (4) hours and 15 minutes of dementia care training. On August 12, 2024, at 2:15 p.m., LALD-C stated the licensee was unaware that ULP-B's record lacked the required dementia training that was assigned to ULP-B by LALD-C. The licensee's 5.03 Dementia Training policy dated January 1, 2023, indicated direct care employees would complete eight (8) hours of initial training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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	01620		

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01620	Continued From page 21 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for four of four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01620		

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01620	Continued From page 22 The findings include: R2 R2 was admitted on November 1, 2022. R2's Service Plan (Private) - Addendum to Contract signed April 22, 2024, indicated R2 required services including medication assistance, medication set up, and medication side effect monitoring. R2's Assessment History by Client as of August 13, 2024, indicated R2's assessments were completing in the following timeframes: August 7, 2023, then 113 days later on November 28, 2023, then 109 days later on March 16, 2024, and then 93 days later on June 17, 2024. R2's assessments exceeded 90 days from the previous completed assessment. R3 R3 was admitted on May 2, 2022. R3's Service Plan (Waiver) - Addendum to Contract signed June 20, 2024, indicated R3 required services including medication assistance and medication set up. R3's Assessment History by Client as of August 13, 2024, indicated R3's assessments were completing in the following timeframes: July 9, 2023, then 121 days later on November 7, 2023, then 144 days later on March 30, 2024, and then 131 days later on August 8, 2024. R3's assessments exceeded 90 days from the previous completed assessment. R4 R4 was admitted on April 9, 2024.	01620		

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01620	Continued From page 23 R4's Service Plan (Private) - Addendum to Contract signed June 12, 2024, indicated R3 required services including medication assistance and medication set up. R4's most recent assessment was completed on April 20, 2024, a total of 115 days passed since R4 had an assessment completed. R5 R5 was admitted on July 23, 2021. R5's Service Plan (Waiver) - Addendum to Contract signed June 20, 2024, indicated R5 required services including medication assistance, medication set up, and medication side effect monitoring. R5's Assessment History by Client as of August 13, 2024, indicated R3's assessments were completing in the following timeframes: August 31, 2023, then 102 days later on December 11, 2023, then 111 days later on March 31, 2024, and then 130 days later on August 8, 2024. R5's assessments exceeded 90 days from the previous completed assessment. On August 13, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated the licensee's expectations require all resident assessments be completed within 90 days of the previous assessment. CNS-D stated the licensee recently had a change in nursing staff and licensee was still in the process of working to bring all resident assessments into compliance. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated January 1, 2023, indicated assessments would be completed	01620		

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01620	Continued From page 24 within 90 days of the previous assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

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01790	Continued From page 25 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for two of two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available.	01790		

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01790	Continued From page 26 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: On August 13, 2024, at 7:00 a.m., during continuous observations, ULP-A and ULP-B were observed providing mediation administration to multiple residents. ULP-A and ULP-B stated their roles included medication administration to multiple residents every shift worked. ULP-A and ULP-B were hired November 13, 2018, and July 24, 2023, respectively. ULP-A and ULP-B's records lacked evidence they were trained, determined to be competent, and delegated the task for management of medications when a resident had an unplanned time away from home. On August 13, 2024, at 1:00 p.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated the licensee was not aware ULPs were required to be trained, tested for competency, and delegated the task for providing medications for residents with unplanned time away when a licensed nurse was not available. LALD-C stated the licensee had not trained any staff for unplanned times away. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated March 10, 2023, indicated when the licensee	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE PLACE	6060 OXBORO AVENUE NORTH OAK PARK HEIGHTS, MN 55082

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01790	Continued From page 27 managed medications for residents, the licensee would train, test for competency, and delegate the task for unplanned times away. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months 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 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 was admitted on May 2, 2022. R3's MD Orders signed June 7, 2023, was	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE PLACE	6060 OXBORO AVENUE NORTH OAK PARK HEIGHTS, MN 55082

(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
01830	Continued From page 28 identified by clinical nurse supervisor (CNS)-D as R3's annual orders. On August 13, 2024, at 11:20 a.m., CNS-D stated R3's annual orders were overdue and the licensee would need to obtain signed orders by R3's primary care provider (PCP). CNS-D stated R3 had an appointment coming up with their PCP and annual orders would be signed. CNS-D was not sure why the annual orders were not signed when R3 had their annual PCP appointment. The licensee's 7.18 Medication & Treatment Orders - Renewal dated March 10, 2023, indicated the licensee would renew resident orders at least every 12 months or more frequently as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of four residents (R2) with medication management services. This practice resulted in a level two violation (a	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 29 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 August 13, 2024, at 7:50 a.m., the surveyor observed R2 receive medication management from unlicensed personnel (ULP)-B. R2 had an unsecured open half full bottle of over the counter (OTC) laxative pills on the counter of their kitchen. R2's bathroom had a mostly full opened bottle of OTC pain relief medication (acetaminophen) and an open box of an OTC antiallergy medications with one pill missing with 23 pills remaining. R2 was admitted on November 1, 2022. R2's Service Plan (private) - Addendum to Contract signed April 22, 2024, indicated R2 required medications assistance services. R2's Assessment dated as of June 17, 2024, read under the section Med Management for all other medications, "Set up medication is kept in a locked box in client's apartment. All other medications are kept locked in a secure area in the nursing office." On August 13, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated all medications in R2's room should have been locked and secured. CNS-D stated R2 should not have access to the OTC medications in their room without a nurse	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE PLACE	6060 OXBORO AVENUE NORTH OAK PARK HEIGHTS, MN 55082

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01880	Continued From page 30 assessment to indicate if R2 was safe to self-manage and administer the medications. CNS-D stated the ULP should have either secured the medications or notified the nurse immediately so the nurse could assess R2 and develop an appropriate medications management plan for the OTC medications. The licensee's 7.11 Medication Storage dated March 10, 2023, indicated when the licensee provided medications management services, medications would be stored according to manufacturer's instructions and based on the nurse's assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R4) with bed rails (also commonly referred to as side rails). This practice resulted in a level two violation (a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE PLACE	6060 OXBORO AVENUE NORTH OAK PARK HEIGHTS, MN 55082

(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
02310	Continued From page 31 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 August 13, 2024, at 11:45 a.m., housing director (HD)-E escorted surveyors to R4's apartment. R4 had a hospital style bed with bilateral upper bed rails in place. The right-side bed rail was in the up position and secured to the bedframe. The left-side bed rails were in the down position and secured to the frame of the bed. R4 was admitted on April 9, 2024. R4's Service Plan (Waiver) - Addendum to Contract signed June 20, 2024, indicated R4 required services for Brace/Appliance/Prosthesis, medication set up, morning cares, and evening cares. R4's Bed Safety Assessment completed on April 20, 2024, indicated R4 required a hospital bed with half rails as ordered by R4's medical provider. The assessment read under the Safety - Bed Safety Zones (Hospital Bed System ONLY) section, "The bed rail meets FDA (Food and Drug Administration) guidelines." The assessment lacked documentation the required zones of entrapment were measured, and measurements recorded on R4's record to ensure R4's safety. On August 13, 2024, at 12:05 p.m., clinical nurse	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30722	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 32 supervisor (CNS)-D stated the licensee was aware measurements were required to be obtained, however CNS-D stated the licensee was not aware the measurements were required to be documented in the resident's record. CNS-D stated they compared the measurements of R4's bed to the requirements and documented the rails met the FDA guidelines but did not record the measurements. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed on August 13, 2024, at 11:48 a.m., indicated under Hospital-style bed rails the measurements of the bedrails were completed and documented. The licensee's 6.28 Side rails policy dated January 1, 2023, indicated measurements of the required zones per FDA guidelines would be completed. The policy failed to indicate the measurements would be documented in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *08/13/24*
Time: 10:42:12
Report: 1023241179

Food and Beverage Establishment Inspection Report

Location:
Oak Ridge Place
6060 Oxboro Avenue North
Oak Park Heights, MN55082
Washington County, 82

Establishment Info:
ID #: 0039374
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514398034
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

Comply By: 08/13/24

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.

OBSERVED OPEN DRINK CONTAINER IN LUNCH SERVICE AREA. ALWAYS USE SEALED CONTAINER OR STORE DRINKS AWAY FROM FOOD SERVICE AREAS.

Comply By: 08/13/24

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

SERVICE FIRE SUPPRESSION SYSTEM REGULARLY.

Comply By: 08/13/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISPLAY COOLER GASKET LOOSE. REPAIR/REPLACE GASKET.

Comply By: 08/13/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

OBSERVED DRAIN FLIES IN KITCHEN AREA AND AROUND MOP SINK. ELIMINATE ADULTS AND TREAT DRAINS TO PREVENT MORE FLIES FROM EMERGING.

Comply By: 08/13/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: DISPLAY COOLER
Violation Issued: No

Process/Item: TPHC/PEA SALAD
Temperature: 45 Degrees Fahrenheit - Location: ON ICE @ 2 HRS
Violation Issued: No

Process/Item: Hot Hold/PORK
Temperature: 155 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Type: Full
Date: *08/13/24*
Time: 10:42:12
Report: 1023241179
Oak Ridge Place

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	5

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

FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED EGGS REQUIRED FOR EGGS TO ORDER
- APPROVED FINISH MATERIALS FOR FOOD PREP AREAS AND CHEST FREEZER AREAS

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

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 1023241179 of 08/13/24.

Certified Food Protection Manager: SHEENA SUKHU

Certification Number: SERVSAF Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
CASSANDRA SMITH
PERSON IN CHARGE

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