Electronically Delivered

August 12, 2024

Licensee
Hastings Senior Health and Living
901 West 16th Street
Hastings, MN  55033

RE:  Project Number(s) SL30651015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30651 | A. BUILDING: _____ B. WING _____ | 07/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HASTINGS SENIOR HEALTH AND LIV | 901 WEST 16TH STREET HASTINGS, MN 55033 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL30651015-0<br><br>On July 15, 2024, through July 16, 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 88 resident(s); 33 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment | 0 800 | | |

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| 0 800 | Continued From page 1<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On July 16, 2024, at 11:00 a.m., survey staff toured the facility with director of maintenance (DM)-F and maintenance technician (M)-G. During the tour, survey staff observed the following:<br>1. In the library, the labeled one-hour fire door was propped open with a magnetic door catch not connected to the existing fire alarm system in the building.<br>2. The labeled 20-minute fire door leading from the corridor into the resident dining room on the | 0 800 | | |

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| 0 800 | Continued From page 2<br><br>main floor was propped open with a door wedge.<br>3. The labeled 20-minute fire door leading from the corridor into the resident activities room on the second floor was propped open with a door wedge.<br>4. The labeled 20-minute fire door leading from the corridor into the nurse office on the main floor was propped open with a door wedge.<br>Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. Fire rated doors must be maintained as designed to protect the opening in which they were installed and to protect adjacent spaces.<br>During the facility tour interview, DM-F and M-G verified these fire doors were not properly maintained.<br>5. A light fixture was plugged into an extension cord in the basement storage room for the kitchen, creating a potential fire hazard.<br>Extension cords must not be used as a substitute for permanent wiring.<br><br>During the facility tour interview, DM-F and M-G verified the improper use of this extension cord and stated it would be removed.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency; | 0 810 | | |

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| 0 810 | Continued From page 3<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to maintain the fire safety and evacuation plan and provide required training. This had the potential to directly affect all residents, staff, and visitors.<br>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 | 0 810 | | |

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| 0 810 | Continued From page 4<br>or has potential to affect a large portion or all of the residents).<br>The findings include:<br>On July 16, 2024, at 1:45 p.m., survey staff toured the lower level of the facility with director of maintenance (DM)-F. During the tour, survey staff observed emergency evacuation floor plans were not posted for the lower level of the building where the parking garage was located. Floor plans for each level of the building must be posted to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, DM-F verified floor plans were not posted for the lower level of the building.<br>On July 16, 2024, director of maintenance (DM)-F and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.<br>TRAINING<br>Record review indicated the licensee failed to provide training to employees on the facility FSEP upon hire and/or at least twice per year evident by the lack of training documentation. An employee fire protection education document dated May 2023 was provided. The names of the employees who attended were not recorded. A safety committee meeting agenda dated June 11, 2024, indicated fire drill procedures were reviewed with new staff. The names of the employees who attended this meeting were not recorded. During an interview on July 16, 2024, at 3:00 p.m., LALD-A stated records to support employee training on the facility FSEP were not available and verified the training frequency was not met.<br>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the | 0 810 | | |

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| 0 810 | Continued From page 5<br><br>lack of training documentation. No documentation for resident training completed in the last year was provided. During an interview on July 16, 2024, at 3:00 p.m. LALD-A explained residents were trained when they moved in and the February 2024 resident newsletter included instructions for what to do if a fire occurs in your apartment. LALD-A verified the training frequency was not met and stated a full scale evacuation training event for residents was scheduled for September 2024.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment | 01370 | | |

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| 01370 | Continued From page 6<br><br>reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-E) completed training and competency evaluations in all required training topics.<br><br>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).<br><br>The findings include:<br><br>On July 16, 2024, at 9:38 a.m. ULP-E was observed administering medications to R3. | 01370 | | |

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| 01370 | Continued From page 7<br><br>ULP-E's employee record lacked evidence training and/or competencies had been completed in the following required topics:<br>- documentation requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the facility;<br>- training on the prevention of falls;<br>- basic nutrition, meal preparation, food safety, and assistance with eating; and<br>- understanding appropriate boundaries between staff and residents and the resident's family.<br><br>On July 16, 2024, at 12:00 p.m. regional director clinical nurse supervisor (RDCNS)-C stated she noted some of the training had not been completed. The training should have been completed prior to ULP-E working independently.<br><br>The licensee's Unlicensed personnel training and competency dated March 21, 2024, identified the following:<br>"Training Content for Unlicensed Personnel and Competency Evaluation.<br>Following are the required training topics for unlicensed personnel, with notation regarding the type of competency evaluation that is required:<br>a. Documentation requirements for all services provided (written or oral test required);<br>f. Training on the prevention of falls for providers working with the elderly or individuals at risk of falls (written or oral test required);<br>i. Basic nutrition, meal preparation, food safety, and assistance with eating (written or oral test required);<br>j. Preparation of modified diets as ordered by a licensed health professional(written or oral test required);<br>m. Understanding appropriate boundaries | 01370 | | |

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| 01370 | Continued From page 8<br><br>between staff and Residents and the Resident's family (written or oral test required);<br>4. Competency of Unlicensed Personnel. Prior to providing assisted living services to a Resident, unlicensed personnel must satisfactorily complete a written or oral test or practical skills test on the topics as identified in 3 above. The RN or Licensed Health Professional will document the competency of all unlicensed personnel on all topics identified in 3 above in the unlicensed person's personnel file. The Director of Health Services is responsible for developing and maintaining a system to track the training and competency of all unlicensed personnel for the RN or other Licensed Health Professional to use when determining which unlicensed personnel may perform a delegated task."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01380 SS=D | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident; | 01380 | | |

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| 01380 | Continued From page 9<br><br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-E) completed training and competency evaluations in all required training topics.<br><br>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).<br><br>The findings include:<br><br>On July 16, 2024, at 9:38 a.m. ULP-E was observed administering medications to R3.<br><br>ULP-E's employee record lacked evidence training and/or competencies had been completed in the following required topics:<br>- observing, reporting, and documenting resident status;<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident. | 01380 | | |

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| 01380 | Continued From page 10<br>On July 16, 2024, at 12:00 p.m. regional director clinical nurse supervisor (RDCNS)-C stated she noted some of the training had not been completed. The training should have been completed prior to ULP-E working independently.<br><br>The licensee's Unlicensed personnel training and competency dated March 21, 2024, identified the following:<br>"Training Content for Unlicensed Personnel and Competency Evaluation.<br>Following are the required training topics for unlicensed personnel, with notation regarding the type of competency evaluation that is required.<br>a. Documentation requirements for all services provided (written or oral test required);<br>b. Reports of changes in the resident ' s condition to the designated supervisor (written or oral test required);<br>c. Basic infection control, including blood-borne pathogens (written or oral test required);<br>d. Maintenance of a clean and safe environment (written or oral test required);<br>e. Appropriate and safe techniques in personal hygiene and grooming, including (practical skills test required for all of the following):<br>i. Hair care and bathing;<br>ii. Care of teeth, gums, and oral prosthetic devices;<br>iii. Care and use of hearing aids; and<br>iv. Dressing and assisting with toileting;<br>f. Training on the prevention of falls for providers working with the elderly or individuals at risk of falls (written or oral test required);<br>g. Standby assistance techniques and how to perform them (practical skills test required);<br>h. Medication, exercise and treatment reminders (written or oral test required);<br>i. Basic nutrition, meal preparation, food safety, and assistance with eating (written or oral test | 01380 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30651 | A. BUILDING: _____ B. WING _____ | 07/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HASTINGS SENIOR HEALTH AND LIV | 901 WEST 16TH STREET HASTINGS, MN 55033 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01380 | Continued From page 11<br>required);<br>j. Preparation of modified diets as ordered by a licensed health professional(written or oral test required);<br>k. Communication skills that include preserving the dignity of the resident and showing respect for the Resident and the Resident ' s preferences, cultural background, and family (written or oral test required);<br>l. Awareness of confidentiality and privacy (written or oral test required);<br>m. Understanding appropriate boundaries between staff and Residents and the Resident ' s family (written or oral test required);<br>n. Procedures to utilize in handling various emergency situations (written or oral test required); and<br>o. Awareness of commonly used health technology equipment and assistive devices (written or oral test required);<br>p. Observation, reporting and documenting resident status (written or oral test required);<br>q. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to the RN or other appropriate personnel (written or oral test required);<br>r. Reading and recording temperature, pulse and respirations of the Resident (practical skills test required);<br>s. Recognizing physical, emotional, cognitive, and developmental needs of the Resident (written or oral test required);<br>t. Safe transfer techniques and ambulation (practical skills test required);<br>u. Range of motioning and positioning (practical skills test required);<br>v. Administering medications or treatments as required (practical skills test required); and<br>w. Training on all delegated tasks or assigned | 01380 | | |

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| 01380 | Continued From page 12<br><br>therapies that the unlicensed personnel will perform (practical skills test showing competency is required).<br>4. Competency of Unlicensed Personnel. Prior to providing assisted living services to a Resident, unlicensed personnel must satisfactorily complete a written or oral test or practical skills test on the topics as identified in 3 above. The RN or Licensed Health Professional will document the competency of all unlicensed personnel on all topics identified in 3 above in the unlicensed person ' s personnel file. The Director of Health Services is responsible for developing and maintaining a system to track the training and competency of all unlicensed personnel for the RN or other Licensed Health Professional to use when determining which unlicensed personnel may perform a delegated task."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based | 01730 | | |

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| 01730 | Continued From page 13<br>on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to include a written statement of medication set up services in the service plan and the medication management plan for the licensee's two residents (R5, R6) who received medication set up services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01730 | | |

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| 01730 | Continued From page 14<br><br>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).<br><br>The findings include:<br><br>R5<br>On July 16, 2024, at 8:30 a.m. unlicensed personnel (ULP)-E was observed to set up and administer R5's medications. ULP-E obtained R5's Tradjenta (diabetic medication) 5 milligram (mg) tablet from a plastic flip top medication minder/med box.<br><br>R5's service plan dated December 4, 2023, indicated R5 received medication administration; however, it failed to identify R5 received medication set up services.<br><br>R5's Individualized Medication Management Plan dated April 22, 2024, indicated R5 received medication administration services; however, it failed to identify R5 received medications set up services.<br><br>R5's medication set up sheets dated July 2024, identified clinical nurse supervisor (CNS)-B set up Tradjenta in a "medication strip" on July 1, 4, 5, 11, and 25, 2024.<br><br>R6<br>R6's service plan dated June 25, 2024, indicated R6 received medication administration; however, it failed to identify R6 received medication set up services. | 01730 | | |

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| 01730 | Continued From page 15<br><br>R6's Individualized Medication Management Plan dated June 26, 2024, indicated R6 received medication administration services; however, it failed to identify R6 received medications set up services.<br><br>R6's medication set up sheets dated July 2024, identified CNS-B set up Bosutinib (used to treat cancer) in a "medication strip" on July 1, 4, 5, 11, 12, 17, 18, and 24, 2024.<br><br>On July 17, 2024, at 2:17 p.m. CNS-B stated she was unaware medication set up services needed to be on the service plan. R5 and R6 were the only residents receiving medication set up service.<br><br>The licensee's MN Medication Management Services dated March 25, 2024, identified "Based on the nursing assessment, the RN will develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written | 01940 | | |

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| 01940 | Continued From page 16<br><br>statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of three residents (R4) receiving treatments.<br><br>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 | 01940 | | |

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| 01940 | Continued From page 17<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on July 15, 2024, at 12:15 p.m. clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed.<br><br>R4's diagnoses included history of cervical fracture (healed), chronic kidney disease, and gout.<br><br>On July 16, 2024, at 7:30 a.m. unlicensed personnel (ULP)-E was observed to don R4's compression stockings and adjust R4's Aspen cervical collar (neck brace), to ensure correct placement and minimize skin irritation and breakdown. ULP-E stated staff remove and change out the cervical collar with showers. Staff monitor for correct placement of the collar and report any concerns about the collar or skin condition to the nurse.<br><br>R4's Physician Orders dated December 12, 2023, indicated R4 to always wear the Aspen cervical collar.<br><br>R4's Resident Service Agreement dated May 16, 2023, included the treatment of compression stockings; however, the service agreement lacked the treatment of R4's cervical collar management.<br><br>R4's Service Check-off List dated July 2024, included Okay to get cervical collar and padding | 01940 | | |

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| 01940 | Continued From page 18<br><br>wet during shower--please use transfer belt while resident transfers in and out of shower. Please assist resident to undress and step wheelchair up to edge of shower then help her to use assist bar and stand and pivot to sit on shower chair. Adjust water temperature to her liking. complete shower task. wash back, legs and feet. shampoo hair. when shower complete help to dry body. Have her step out onto a bathmat and wheelchair after shower. With resident sitting steady in chair, please change padding of cervical collar and dry plastic parts of brace. With resident holding head steady in neutral position, detach front of collar and lift away. Then gently slide out back panel of collar. Look for any skin impairment on neck and notify nurse of any impairment. Then, while supporting neck, gently wash and dry neck and apply lotion. Then replace back panel first under neck, then flare sides of front panel outward. Place chin piece directly under the chin. Generally, the chin should not extend beyond the edge of the plastic. Push the sides of the front panel up over the shoulder muscles around the neck and re-secure to back panel with attached straps. Assist with dressing and lotion application to body as resident wishes. Before you leave always make sure bathroom floor is dry and picked up.<br><br>R4's Individualized Treatment and Therapy plan dated June 19, 2024, indicated "other delegated service" removal of cervical collar and cleaning of skin under the collar, changing of cervical collar padding and replacement of cervical collar.<br><br>On July 16, 2024, at 12:00 p.m. regional director clinical nurse supervisor (RDCNS)-C indicated R4's service plan lacked the treatment of R4's cervical neck brace management. | 01940 | | |

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| 01940 | Continued From page 19<br><br>The licensee's Service Plan policy dated February 12, 2024, indicated the licensee would include a description of the services provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01940 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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 storage of oxygen. This had the potential to affect all 88 residents, staff, and visitors of the facility.<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living facility | 02310 | | |

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| 02310 | Continued From page 20<br><br>license. The facility was licensed for a bed capacity of 90 residents and had a current census of 88 residents.<br><br>R6 was admitted to the assisted living facility on March 13, 2020.<br><br>R6 had diagnoses to include heart failure and chronic lung disease with oxygen dependence.<br><br>R6's Service Plan dated June 25, 2024, included the service of oxygen management.<br><br>R6's Treatment and Therapy plan dated June 26, 2024, indicated continuous oxygen with a flow rate of two liters/minute.<br><br>On July 16, 2024, at 2:10 p.m. the surveyor observed R6 in his living room area seated in a recliner with a nasal cannula connected to an oxygen concentrator (a unit that converts air in the room to a concentrated form of oxygen through a cannula). Additionally, the surveyor observed a large (3000 ft³) oxygen tank placed in the corner just behind R6's recliner in the corner of the room. The oxygen tank was free standing and not secured in a rack or by a chain to prevent it from tipping and possibly causing significant injury or damage. The tank was in the off position but had a connected flow meter to allow for emergency oxygen supply in the event R6's concentrator or smaller oxygen tanks failed.<br><br>On July 16, 2024, at 3:30 p.m. clinical nurse supervisor (CNS)-B indicated the large tank had previously been secured by a tank stander. CNS-B stated she was uncertain as to why the tank was currently unsecured.<br><br>Minnesota Department of Health (MDH) internal | 02310 | | |

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| 02310 | Continued From page 21<br><br>document titled, Oxygen Cylinder Storage Requirements, dated April 16, 2020, which was based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code states:<br>Volumes between 300 ft³ and 3000 ft³ of oxygen must be stored in special designated rooms that meet the following requirements:<br>-Rooms must be non-combustible or limited-combustible construction (gypsum wallboard, tiled walls, etc.) with a door that can be secured from unauthorized entry (i.e., Locked).<br>-Oxygen may not be stored with other flammable gases or liquids.<br>-Oxygen cylinders must maintain a minimum distance of 20 ft. from combustibles (5 ft. if room is sprinklered) or placed within an enclosed cabinet having a fire rating of at least ½ hour.<br>-Cylinders must be secured in racks or by chains.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |

DEPARTMENT OF HEALTH

Type: Full
Date: *07/16/24*
Time: 11:01:10
Report: 1036241134

# Food and Beverage Establishment Inspection Report



**Location:**
Hastings Senior Health And Liv
901 West 16th Street
Hastings, MN55033
Dakota County, 19

**Establishment Info:**
ID #: 0038857
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6514806300
ID #:

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

No NEW orders were issued during this inspection.

**Surface and Equipment Sanitizers**

QUATERNARY AMMONIA: = 200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY
Violation Issued: No

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

**Food and Equipment Temperatures**

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: FRIGIDARE FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: FRIGIDARE FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -10 Degrees Fahrenheit - Location: FRIGIDAIRE FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR WAS DEB JACOBSON. INSPECTION CONDUCTED IN PRESENCE OF KARI ROBINSON, THE PERSON IN CHARGE, AND MARK WUOTILA, THE CFPM. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND SURVEYOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. LUNCH AND DINNER FOOD SERVICE IS PROVIDED BY FACILITY STAFF AND BROUGHT OVER FROM THE HASTINGS CARE CENTER KITCHEN ACROSS THE STREET..

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- THERMOMETER USE/CALIBRATION
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- DATE MARKING
- PROPER FOOD STORAGE
- ANSI 184 DISH WASHER

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

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

I acknowledge receipt of the inspection report number 1036241134 of 07/16/24.

Certified Food Protection Manager MARK WUOTILA

Certification Number: FM69602 Expires: 05/31/25

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

Signed: _____
KARI ROBINSON
NUTRITION DIRECTOR

Signed: _____
Jeff Johanson