Electronically Delivered

July 11, 2022

Administrator
River Oaks at Shady Ridge LLC
225 Shady Ridge Road Northwest
Hutchinson, MN 55350

RE: Project Number SL32681015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
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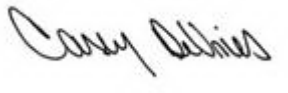
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
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State Evaluation Team
85 East Seventh Place, Suite 220
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Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32681	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT SHADY RIDGE LLC	225 SHADY RIDGE ROAD NW HUTCHINSON, MN 55350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL32681015-0 On June 14, 2022, through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were thirty-one (31) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 680	Continued From page 2	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure its emergency preparedness plan (EP) was prominently posted and emergency exit diagrams were posted, including on the 2nd floor. In addition, the licensee failed to ensure its missing resident policy contained all required content and	0 680		

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0 680	Continued From page 3 was reviewed at least quarterly. This had potential to affect all residents, staff and any visitors to the facility. 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: LACK OF POSTED INFORMATION ABOUT EMERGENCY PLAN Following the entrance conference on June 14, 2022, at approximately 10:45 a.m., the surveyor briefly toured the facility with the owner and assistant administrator. On the main floor in the day room area the surveyor observed a three-ringed binder labeled "Emergency" on a table next to the phone. There lacked any other disclosure or posted information relating to the licensee's emergency plan on either 1st or 2nd floor. On the 2nd floor there lacked any posting or disclosure of emergency exit diagrams. Assistant administrator (ADM)-B provided the surveyor with the licensee's emergency preparedness plan (EP), which contained an undated Missing Resident policy and procedure. MISSING PERSON POLICY NOT REVIEWED The licensee's missing person policy was part the EP plan contained in the three-ringed binder. The missing resident policy/procedure in the binder, did not identify the staff by position description	0 680		

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0 680	Continued From page 4 who was responsible for searching for missing residents or suspected missing residents. Also, there was no evidence in the licensee's EP plan when the policy had been implemented or reviewed. The policy/procedure did not indicate how frequently the policy needed to be reviewed. On June 16, 2022, at approximately 2:48 p.m., ADM-B stated their EP plan was revamped as of March this year following a survey at one of the company's other sites. ADM-B stated the missing person document here was not dated and also the procedure did not identify staff by position title who were responsible to conduct a missing resident search. ADM-B also stated there was nothing posted about the plan or exit diagrams on the 2nd floor but noted there were exit diagrams on the inside door of each resident's room. The licensee provided a different Missing Client policy, revised March 24, 2020, which indicated when a client [resident] is not where the client can reasonably be expected to be, staff promptly implement the missing client procedure. The policy, which contained outdated verbiage, lacked the content described above and did not address how frequently the missing resident policy was to be reviewed or evaluated. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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,	0 800		

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0 800	Continued From page 5 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 14, 2022, at approximately 11:20 a.m. with Assistant Administrator (ADM)-B, the following items were observed: - The baseboard heat cover in room #36 was bent and/ or broken. - An extension cord was used as the permanent wiring source for the outdoor roof heat trace in the courtyard for residents.	0 800		

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0 800	Continued From page 6 - One of the support posts for the elevated deck in the courtyard was severely bowed and appeared to be compromised structurally. - The egress door by Mechanical Room #2 was obstructed by medical carts and various medical equipment compromising exiting for staff and residents due to not maintaining the path of egress. - Multiple plug strips were daisy chained in Mechanical Room #2 creating a possible fire risk. - The exhaust fan was hanging out of the wall in the restroom by Linen Closet #2. - The abandoned furnace exhaust line was cut off and open to the exterior roof in the mechanical room by the upstairs recreation room allowing unconditioned air and possible animals to enter the building. - The abandoned gas line was unsecured and hanging from the ceiling and obstructing the door from fully opening in the mechanical room by the upstairs recreation room. - Several resident mattresses were stored on the floor in the water draining from the condensate line for cooling from the air handling equipment creating a mold issue and obstructing the clearance and access to mechanical equipment in the mechanical room on the main level. - Multiple plug strips were daisy chained with an extension cord feeding off one of the plug strips being used as permanent wiring and being routed through a wall to serve an adjacent room in the mechanical room on the main level. The plug	0 800		

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0 800	Continued From page 7 strips were all attached by a multi-tap plug device with all these elements creating a fire risk. - The drinking fountain was not operational by the main entrance. - The air conditioning disconnect was hanging by the live electrical wires only and not attached to the building near the lower-level outdoor smoking area for residents. An interview with ADM-B verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 8 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 14, 2022, at approximately 12.50 p.m. with Assistant Administrator (ADM)-B on the fire safety and evacuation plan, fire safety and evacuation	0 810		

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0 810	Continued From page 9 training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, ADM-B indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ADM-B indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. During interview, ADM-B indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, ADM-B stated that the licensee policy is to train employees on fire safety and evacuation annually after initial hire. A policy was requested but was not able to be provided. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own	0 810		

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0 810	Continued From page 10 evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, ADM-B stated that the licensee does provide education on fire safety and evacuation at admission and indicated that there is also follow up at resident council but could not provide any documentation to show compliance. A policy on resident training for fire safety and evacuation but one was not able to be provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Documentation of drills provided only showed drill dates for 12/30/2021, 2/28/2022, and 4/17/2022, and did not indicate if evacuation was practiced or conducted as part of the drill. During interview, ADM-B indicated that evacuation was conducted during the drills but could not provide documentation to show compliance. ADM-B verified that drills were not conducted every other month as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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01440	Continued From page 11 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN) supervised staff performing delegated nursing services within 30 days after first performing those tasks for two of two unlicensed personnel ((ULP)-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULPF ULP-F was hired October 11, 2021, to provide	01440		

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01440	Continued From page 12 direct-care services to the licensee's residents. On June 15, 2022, at approximately 6:42 a.m., the surveyor observed ULP-F prepare then administer medications to R5. A few minutes later ULP-F prepared medications for R1 and administered R1's medications, including a narcotic via the buccal (between the cheek and molars inside the mouth) route. ULP-F's employee record lacked evidence the RN supervised ULP-D within 30 days after performing delegated tasks. ULP-G ULP-G was hired October 14, 2021, to provide direct-care services to the licensee's residents. On June 16, 2022, at approximately 10:45 a.m., the surveyor observed ULP-G check the compression stocking on R1's left hand, which ULP-G stated she put on earlier that morning. ULP-G also stated she had to check R1's "0-2 Sats" (oxygen saturation) everyday as R1 utilized oxygen as needed stating, "we watch that" for her. ULP-G's employee record lacked evidence the RN supervised ULP-D within 30 days after performing delegated tasks. On June 16, 2022, at approximately 3:22 p.m., registered nurse (RN)-A stated unlicensed staff were to be supervised "within the 30 days" and said if there was not documentation in the employees' files then it was not done. The licensee's Supervision of Licensed and Unlicensed Personnel policy, revised July 20, 2021, indicated both licensed and unlicensed	01440		

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01440	Continued From page 13 staff would be supervised by a designated supervisor to ensure the staff performed their job duties competently, consistently and according to standards that may apply. The policy indicated an RN would supervise staff who performed delegated nursing, treatment or therapy services and the direct supervision would occur within 30 calendar days after the staff member began working and first performed delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01530 SS=F	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	01530		

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01530	Continued From page 14 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 one of three employees (registered nurse (RN)-A) received the required amount of dementia-care training, in the required time frame, with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee provided services under an assisted living license. RN-A was hired October 6, 2020, to provide direct care and services to the licensee's residents and to provide oversight and supervision to the licensee's unlicensed personnel under the former comprehensive license. RN-A began providing care and services under the licensee's assisted living with dementia care license on August 1, 2021. Review of R1, R2 and R3's medical records	01530		

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01530	Continued From page 15 indicated RN-A completed numerous assessments and developed medication and treatment plans for the residents. RN-A's training transcripts and records contained evidence RN-A completed a total of 4.25 hours of dementia training since employment start date. RN-A's dementia care training total hours was less than the minimum 8.0 hours required within 120 working hours. On June 16, 2022, at approximately 3:25 p.m., RN-A acknowledged her dementia-care training lacked the required 8 hours. RN-A stated it was neglected in an effort to make sure everything else that was required got done. The licensee's Assisted Living Dementia Training policy, revised August 1, 2021, indicated assisted living staff would receive required training on dementia care during orientation and annually. The policy indicated supervisor of direct care staff would complete a minimum of 8 hours initial training on dementia care topics within 120 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (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	01730		

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01730	Continued From page 16 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: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (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. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01730		

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01730	Continued From page 17 review, the licensee failed to ensure the registered nurse (RN) developed an individualized medication management plan to include all required content for three of three residents (R1, R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R1 R1's Service Agreement dated January 5, 2022, indicated services included medication management. R1's Client Individualized Medication Management Plan dated January 5, 2022, indicated: R1 received medication administration 4x (times) daily; R1's medications were secured outside client's private home; the agency's process to verify that the medication management services are provided by staff consistent with this plan was on the EMAR (electronic medication administration record)/Eldermark (Trade name of the electronic record); and if the client, the client's representative or our home care staff identifies any problems related to medications, they should immediately notify the RN in person or by calling [phone number listed]. On June 15, 2022, at approximately 6:42 a.m., the surveyor observed unlicensed personnel	01730		

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01730	Continued From page 18 (ULP)-F prepare and administer R1's medications. R1's prescriber's orders dated June 3, 2022, included a steroid, anti-anxiety medications, two anti-depressants, three blood pressure medications, medication for high cholesterol, constipation, oral, topical and buccal (in the mouth) medications for pain, a medication for mood stabilization, and medication to treat esophageal reflux and two types of insulin for diabetes. R1's medication administration record (MAR) for June 2022 was reviewed. The MAR lacked information to verify services provided were consistent with prescriber's orders and reviewed by the RN to monitor complications or adverse reactions. R1's medication management plan did not indicate: the licensee stored R1's medications in a locked medication cart in the facility; verification that medications were administered as prescribed; and procedures to notify an RN when problems arose. On June 16, 2022, at approximately 9:05 a.m., RN-D stated "we are aware" R1's medication plan did not have the specifics on what was needed on the plan. R2 R2's Service Agreement dated January 14, 2022, indicated services included medication management. R2's Client Individualized Medication Management Plan dated July 24, 2019, indicated: R2 received medication administration 3x daily;	01730		

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01730	Continued From page 19 R2's medications were secured outside client's private home; the agency's process to verify that the medication management services are provided by staff consistent with this plan was "Eldermark"; and if the client, the client's representative or our home care staff identifies any problems related to medications, they should immediately notify the RN in person or by calling [phone number listed]. On June 15, 2022, at approximately 8:53 a.m., the surveyor observed ULP-G administer R1's morning medications. R2's prescriber's orders dated April 12, 2022, included an inhaler for chronic obstructive pulmonary disease, anti-seizure, mood stabilizer, and anti-depressant and as-needed medications for shortness of breath, managing secretions, anxiety, pain and hallucinations. R2's medication management plan did not indicate: the licensee stored R2's medications in a locked medication cart in the facility; verification that medications were administered as prescribed; and procedures to notify an RN when problems arose. R3 R3's Service Agreement dated January 5, 2022, indicated services included medication management. R3's Client Individualized Medication Management Plan reviewed June 13, 2022, indicated: R3 received medication administration 3x daily by licensed and unlicensed staff and R2's medications were secured outside client's private home and insulin was stored in refrigerator in medication room.	01730		

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01730	Continued From page 20 R3's prescriber's orders dated December 15, 2021, included daily aspirin, three blood pressure medications, medications for cholesterol, esophageal reflux, diabetes management, edema, an antidepressant, dietary supplements, a daily vitamin and insulin. R3's medication management plan did not indicate: the licensee stored R3's medications in a locked medication cart in the facility; procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arise with medication management services and; 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. On June 16, 2022, at approximately 9:07 a.m., RN-A acknowledged and said R3's medication plan was not complete. RN-L, also present during the interview, said that after a state survey at their other site they were supposed to complete new medication management forms for all residents, but "have not done that." RN-L talked about and showed the surveyor updated forms they were working on implementing. The licensee's Individualized Medications Management Plan document, undated, indicated it included: a description of the storage of medications based on resident's needs and preferences; documentation of specific resident instructions relating to the administration of medication for our staff on your MAR; procedures for staff notifying a registered nurse when a problem arises with medication management	01730		

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01730	Continued From page 21 services and any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure as needed (PRN) medications included documentation for effectiveness after administration for two of three residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760		

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01760	Continued From page 22 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's Service Agreement and Client Individualized Medication Management Plan, each dated January 5, 2022, indicated the resident received medication management services, including medication administration. R1's prescriber's orders dated June 3, 2022, included Xanax 0.5 mg (milligrams), administer 0.5 mg by mouth once daily as needed for anxiety. The order was amended June 21, 2022, to administer twice daily as needed. R1's medication administration record (MAR) for May 2022 and June 1, 2022, to June 15, 2022, indicated the following: -May: Xanax 0.5 mg by mouth PRN was administered 21 times; 7 of the 21 administrations lacked documentation of effectiveness. -June: Xanax 0.5 mg by mouth PRN was administered 10 times; 4 of the 10 administrations lacked documentation of effectiveness. R3 R3's Service Agreement dated January 5, 2022, and R3's Client Individualized Medication Management Plan reviewed June 13, 2022, indicated the resident received medication	01760		

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01760	Continued From page 23 management services, including medication administration. R3's prescriber's orders dated December 15, 2021, included Naproxen (pain medication) 500 mg administer 500 mg by mouth twice daily as needed for gout. R3's medication administration record (MAR) for May 2022 and June 1, 2022, thorough June 15, 2022, indicated the following: -May: Naproxen 500 mg by mouth PRN was administered 18 times; 5 of 18 administrations lacked documentation of effectiveness. -June: Naproxen 500 mg by mouth PRN was administered 24 times; 2 of 24 administrations lacked documentation of effectiveness. On June 16, 2022, at approximately 9:11 a.m., registered nurse (RN)-A stated staff should be documenting follow-ups for as needed medication use and that has been an issue. RN-A acknowledged PRN follow up was not consistent, required more staff education and was "a work in progress." The licensee's Administration and Documentation of PRN Medications policy, reviewed March 24, 2020, indicated PRN medications would be administered consistent with parameters specified in the prescriber's prescription and with the procedures identified by the RN for administration and documentation of the PRN. The policy indicated the RN would document in the record whether staff must check back with the client following administration to determine whether the PRN was effective. No further information was provided.	01760		

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01760	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	01790		

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01790	Continued From page 25 (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 interview and record review, the licensee failed to ensure staff were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away for two of two unlicensed personnel ((ULP)-G, ULP-H) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01790		

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	32681	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01790	Continued From page 26	01790		

is 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:

ULPF
ULP-F was hired October 11, 2021, to provide direct-care services to the licensee's residents.

On June 15, 2022, at approximately 6:42 a.m., the surveyor observed ULP-F prepare then administer medications to R5. A few minutes later ULP-F prepared medications for R1 and administered R1's medications, including a narcotic via the buccal (between the cheek and molars inside the mouth) route.

ULP-G
ULP-G was hired October 14, 2021, to provide direct-care services to the licensee's residents.

On June 15, 2022, at approximately 8:04 a.m., the surveyor observed ULP-G administer medications to R6.

ULP-G and ULP-H's employee record lacked evidence to indicate they had been trained and demonstrated competency to provide medications to residents for unplanned times away from home when the nurse was not available.

On June 16, 2022, at approximately 3:27 p.m., registered nurse (RN)-A verified both ULP-G and ULP-H were trained and passed medications to residents. RN-A said unplanned time away was not a current training competency for the unlicensed staff. RN-L, also present during the

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01790	Continued From page 27 interview, stated they have a policy for unplanned time away and agreed this was a competency that should be implemented and tested. RN-L said this issue had come up on a survey at a sister facility and expressed understanding of the requirement. The licensee's Medications for a Client Who Will Be Away From Home When Medications Are Scheduled policy, revised March 24, 2020, indicated the agency will make every effort to accommodate clients' needs of our agency control access to their medications and they have planned or unplanned times away from home when they are scheduled to take prescribed medications. The policy indicated the RN may delegate this task to unlicensed personnel if the RN has trained and competency tested the ULP staff on procedures to follow when giving medications to clients who will be away from home when medications are scheduled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen 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 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	01940		

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01940	Continued From page 28 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (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. 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) developed or updated individual treatment/therapy plans for two of two residents (R1, R3) who had ordered treatments with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01940		

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01940	Continued From page 29 found to be pervasive). The findings include: R1 R1's prescriber's orders dated January 5, 2022, included apply TED (thrombo-embolic deterrent, specialized hosiery designed to help prevent edema and blood clots) stocking to left forearm and another order dated June 3, 2022, for oxygen via nasal cannula at 2 liters per minute and titrate down as needed. On June 15, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-F place a TED hose on R1's left arm. On June 16, 2022, at approximately 10:45 a.m. R1 said staff check her oxygen levels every day and she used oxygen as needed if she was short of breath or if her oxygen levels indicated. R1 disclosed having a concentrator in her closet and also portable oxygen machine in her room; both were observed by the surveyor. R1's Treatment/Therapy Management plan dated January 5, 2022, lacked identification of treatment of TED hose use for the left arm and use of oxygen as needed, including: -a written statement of the treatment or therapy services that will be provided to the resident; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel (ULPs); -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was	01940		

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01940	Continued From page 30 administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reaction. R3 R3's prescriber's orders dated December 15, 2021, included Accucheck (blood sugar testing) twice daily at 7:00 a.m. and 8:00 p.m., for diabetes, and apply ACE wraps to both legs daily; apply to lower extremities from knee to ankle every morning when resident is getting up from bed for bilateral extremity edema. On June 16, 2022, at approximately 11:11 a.m., the surveyor observed unlicensed personnel (ULP)-G apply ACE wraps to both of R1's lower legs. R3's Treatment/Therapy Management plan modified June 13, 2022, lacked the following content: -procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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 reaction. On June 16, 2022, at approximately 9:07 a.m., RN-A stated they were implementing new forms for medication and treatment management and realized this was not done after being cited from a survey at another facility they owned. RN-L, also present during the interview, acknowledged and stated R1 and R3's treatment plan did not have all the content and was missing a page. RN-L said they were aware of the issue and were	01940		

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01940	Continued From page 31 working to be in compliance. The licensee's Individualized Treatment and Therapy Management Plan document, undated, indicated the licensee will provide ordered or prescribed treatment and therapy services. The document indicted the treatment management plan included: description of the treatment management service that will be provided; documentation of specific resident instructions relating to the treatments or therapy administration will be recorded on the TAR/MAR (Treatment/medication administration record); procedure for notifying a RN or appropriate licensed health professional when a problem arises with treatment or therapy service and any resident-specific requirement relating to documentation of treatment and therapy received, verification that all treatment and therapy was administer as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reaction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 32 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R1) who had ordered treatments with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's prescriber orders dated January 5, 2022, included apply TED stocking (thrombo-embolic deterrent, specialized hosiery designed to help prevent edema and blood clots) to left forearm;	01950		

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01950	Continued From page 33 and dated June 3, 2022, included oxygen via nasal cannula at 2 liters per minute and titrate down as needed. On June 15, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-F place a TED hose on R1's left arm. ULP-F said staff put on the hose in the morning, remove at night and that the night staff was to wash and clean it. ULP-F stated she looked at R1's skin to make sure there was no irritation and if R1 had any bad swelling, she would let the nurse know. ULP-F said she was trained by the nurse on how to apply TED hose and usually the stockings were for legs, not arms. On June 16, 2022, at approximately 8:11 a.m., ULP-G stated R1 used oxygen as needed after she returned from the hospital. ULP-G said staff check R1's "0-2 SATS" (oxygen saturation) every day and if it is below 90%, staff encourage R1 to put the oxygen on and if R1 was short of breath ULP-G stated they would let the nurse know. ULP-G also thought staff would be responsible to change the tubing but did not know how frequently. ULP-G stated she was trained on caring for a resident who used oxygen. On June 16, 2022, at approximately 10:45 a.m., R1 said staff check her oxygen levels every day and she used oxygen as needed if she was short of breath or if her oxygen levels indicated. R1 disclosed having a concentrator in her closet and also portable oxygen machine in her room, both were observed by the surveyor. R1's Service Plan, dated June 16, 2022, included a scheduled service for unlicensed staff to assist R1 in putting TED stocking on left forearm, on in a.m. and off p.m. There was no additional	01950		

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01950	Continued From page 34 information. R1's Service Delivery record for June 2022, indicated staff provided the service for R1's TED stocking. R1's June 2022, medication administration record (MAR) directed oxygen at 2 liters per minute, may titrate down if 0-2 SATS are good. Must be above 85. Record 0-2 SAT every shift. There was no additional information. R1's record lacked specific instructions related to the application of the TED hose and the use of oxygen such as monitoring for issues or complications, and to whom or when to report when issues arise or who was responsible for cleaning stockings, monitoring oxygen tubing for kinks and cleaning and changing the oxygen tubing. On June 16, 2022, at approximately 9:07 a.m., RN-A acknowledged and stated R1's treatment plan was not updated and the instructions for resident treatments are probably not as specific as they should be. RN-A said instructions for R1's treatments should all be on the MAR. RN-A talked about the new forms they had developed for the medication and treatment management plans. RN-L, also present during the interview, said they were cited regarding treatment plans during a survey from another site they owned and acknowledged they were aware of the issue and were working to be in compliance. The licensee's Individualized Treatment and Therapy Management Plan document, undated, indicated the licensee will provide ordered or prescribed treatment and therapy services. The document indicted the treatment management	01950		

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01950	Continued From page 35 plan included: description of the treatment management service that will be provided; documentation of specific resident instructions relating to the treatments or therapy administration will be recorded on the TAR/MAR (Treatment/medication administration record); procedure for notifying a RN or appropriate licensed health profession when a problem arises with treatment or therapy service and any resident-specific requirement relating to documentation of treatment and therapy received, verification that all treatment and therapy was administer as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reaction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/14/22*
Time: 10:00:25
Report: 1033221045

Food and Beverage Establishment Inspection Report

Location:
River Oaks at Shady Ridge
225 Shady Ridge Road NW
Hutchinson, MN55350
Mc Leod County, 43

Establishment Info:
ID #: 0006056
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
River Oaks at Shady Ridge, LLC

Phone #: 7632586284
ID #: 46744

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

Facility does not have means to measure their high temperature dish machine.

Comply By: 06/28/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

Facility does not have a test kit to measure sanitizing concentration.

Comply By: 06/28/22

5-500 Refuse and Recyclables

5-501.17

MN Rule 4626.1260 Provide covered receptacles in the toilet room for sanitary napkins or diapers.

Facility does not have covered receptacles in toilet room.

Comply By: 07/05/22

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200 at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Jello-Fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: Milk Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: French Dressing-Fridge
Violation Issued: No

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

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 1033221045 of 06/14/22.

Certified Food Protection Manager: Aaron A Krienke

Certification Number: FM109675 Expires: 02/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Aaron A Krienke

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