Electronically Delivered

October 27, 2022

Administrator
Ridgeway On German
715 South German Street
New Ulm, MN 56073

RE: Project Number(s) SL20555015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 5, 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:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20555	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON GERMAN	715 SOUTH GERMAN STREET NEW ULM, MN 56073

(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: SL20555015 On October 3, 2022, through October 5, 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 36 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 October 4, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 660	Continued From page 2	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include a facility TB risk assessment. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	0 660		

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0 660	Continued From page 3 portion or all of the residents). The findings include: During the entrance conference on October 3, 2022, at 10:15 a.m. with licensed assisted living director (LALD)-A and registered nurse (RN)-B, a surveyor requested to review the facility's TB risk assessment. RN-B provided the TB Risk Assessment following the entrance conference. A review of the Facility TB Risk Assessment dated December 9, 2021, revealed on page one, number one, the national rate for incidence of TB was not completed. The following three pages of the assessment were also blank. The previous Facility TB Risk Assessment had been completed on July 24, 2019. On October 5, 2022, at 10:22 a.m. RN-B confirmed the current Facility TB Risk Assessment was incomplete. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated the CNS (clinical nurse supervisor) or RN is responsible for establishing and maintaining the TB prevention control program with responsibilities to include: b. Completion of a written TB risk assessment for the facility using the form provided by the Minnesota Department of Health. c. Annual review and revision as needed of the TB risk assessment for the facility. Based on the risk assessment, CNS or RN will determine the frequency of TB screening and testing necessary for assisted living staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 4 (21) day	0 660		
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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors.	0 680		

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0 680	Continued From page 5 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 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: On October 5, 2022, at 1:30 p.m. the surveyor reviewed the emergency preparedness plan with licensed assisted living director (LALD)-A. The licensee's EP plan consisted of several documents and policies dated June 17, 2022. The plan included a hazard and vulnerability assessment and various policies/procedures. The licensee's plan lacked the following required content: -Development of all policies/procedures for: -Provision of subsistence needs for staff and residents; -Tracking of staff; -Arrangement with other facilities and providers to receive residents; -Roles under a 1135 waiver declared by the Secretary; - Emergency prep training and testing; - Emergency prep training program; - Emergency prep testing requirements On October 5, 2022, at approximately 1:30 p.m. LALD-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include the above requirements. LALD-A indicated she was aware of the	0 680		

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0 680	Continued From page 6 emergency preparedness requirements, but had been busy with COVID and had not prioritized the EP plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 7 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 provide required resident training on fire safety and evacuation and failed to conduct required 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 October 4, 2022, at approximately 9:50 a.m. with Licensed Assisted Living Director (LALD)-A and Director of Maintenance (DM)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own 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, LALD-A stated that the facility did not	0 810		

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0 810	Continued From page 8 have documentation or a policy on resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills conducted by the licensee were in December of 2021 and April of 2022 with no further drills being documented. During interview, LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	01620		

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01620	Continued From page 9 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R3's service plan dated September 7, 2022, indicated R3 received services including bathing, dressing, and medication administration. R3's last three assessments were requested. Assessments dated May 17, 2022, August 17, 2022 (92 days from the previous assessment), and September 12, 2022, were provided.	01620		

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01620	Continued From page 10 On October 5, 2022, at 11:02 a.m. RN-B verified R3's May and August assessments were greater than 90 days apart. RN-B confirmed the electronic health record alerts them when assessments are due, and stated she and RN-E had been working on completing them timely. The licensee's Initial and Ongoing Nursing Assessments of Residents policy dated August 1, 2021, indicated: 1. The CNS (clinical nurse supervisor) or RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment. b. 14-day assessment: completed up to 14-days after start of services. c. Ongoing assessment: completed periodically but no less than every 90-days. d. Change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700		

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01700	Continued From page 11	01700		

resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

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) conducted a face-to-face medication management assessment to include all required content for one of three residents (R3), prior to providing medication management services.

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:

During the entrance conference on October 3, 2022, at 10:15 a.m., RN-B confirmed the licensee

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON GERMAN	715 SOUTH GERMAN STREET NEW ULM, MN 56073

(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
01700	Continued From page 12	01700		

provided medication management services to many of the residents receiving assisted living services.

R3's diagnoses included rheumatoid arthritis (a chronic inflammatory disease the affects the joints), age-related macular degeneration (a vision impairment resulting from deterioration of the central part of retina, a thin layer at the back of the eye on the inner side), iron deficiency anemia, and hypercholesterolemia (high cholesterol).

R3's Service Plan Agreement dated September 7, 2022, indicated R3 received services including medication administration.

R3's prescriber orders signed May 13, 2022, included the following medications: one antineoplastic antimetabolite (to treat rheumatoid arthritis), four supplements, one antihyperlipidimic (to treat high cholesterol), and one eye drop.

On October 4, 2022, at 10:06 a.m. the surveyor observed unlicensed personnel (ULP)-D administering R3's scheduled supplements including a vitamin for the eyes.

R3 began receiving services from the licensee on May 9, 2022. R3's record indicated a medication management assessment was completed on May 17, 2022 (eight days after start of services).

On October 5, 2022, at 10:22 a.m. RN-B confirmed R3 began receiving medication administration services on May 9, 2022. RN-B further confirmed a medication management assessment with all required components, had not been completed until the resident's 14-day assessment on May 17, 2022. RN-B verified this

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01700	Continued From page 13 was their process for all new admissions. The licensee's Initial and Ongoing Nursing Assessments of Residents policy dated August 1, 2021, indicated: 1. The CNS (clinical nurse supervisor) or RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: Completed periodically but no less than every 90-days d. Change in resident condition 3. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the CNS or RN, and if there is awareness of these records. Comprehensive assessment includes: d. Physical health status, including: v. Medication review including OTC (over the counter) medications, prescription medications and supplements including: 1. Reason taken 2. Side effects, contraindications, allergic or adverse reactions 3. Actions to address side effects, contraindications, allergic or adverse reactions 4. Dosage 5. Frequency of use 6. Route administered 7. Resident difficulties taking medications 8. Self-administration versus other type of administration 9. Resident preferences for taking medications	01700		

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01700	Continued From page 14 10. Medications management interventions to prevent drug diversion by the resident or others who have access to medications 11. Instructions to the resident and resident's legal/designated representative on interventions to manage the resident's medications and prevent medication diversion vi. Use and effect of medications including any psychotropic meds The licensee's Resident Pre-Admission Assessment and Monitoring Process-Nursing policy dated August 1, 2021, indicated: 7. When the 14-day assessment is completed this will include: a. evaluate the resident's medication management services and the resident's medications and complete a medication management plan if the facility provides services related to the resident's medications No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=D	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	01790		

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01790	Continued From page 15 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; (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;	01790		

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01790	Continued From page 16 (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 the registered nurse (RN) trained and ensured competency for two of two unlicensed personnel (ULP-D, ULP-F) providing medications for residents with unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: ULP-D and ULP-F were hired to provide direct care to the licensee's residents on August 23, 2021, and February 14, 2022, respectively. ULP-D and ULP-F's employee records lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home.	01790		

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01790	Continued From page 17 On October 5, 2022, at 1:30 p.m. RN-B confirmed ULP-D and ULP-F's employee record lacked documentation to indicate they had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home. RN-B stated she verbally trained the ULP but did not document it. The licensee's undated Medications When a Resident Will Be Away from the Building policy indicated: 4. For situations when there will be a short-term absence that is not known in advance and a licensed nurse is not available to put the medications into a container for the resident or the resident's responsible person to take out of the building: a. The Director of Health Services/RN will establish procedures for unlicensed staff to follow when giving medications to the resident or resident's responsible person to take out of the building. These procedures will address containers, labeling, information to give to the family about the medications regarding dosage, route, timing, etc. (e.g., copy of the MAR) and documenting who took the medications and the time and date. b. The Director of Health Services/RN will train and competency test the unlicensed staff on these procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 18 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted October 4, 2022, at approximately 9:50 a.m. with Licensed Assisted Living Director (LALD)-A and Director of Maintenance (DM)-C on the hazard vulnerability assessment for the physical	02040		

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02040	Continued From page 19 environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A verified that the licensee had not conducted a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/04/22*
Time: 09:00:00
Report: 1033221159

Food and Beverage Establishment Inspection Report

Location:
Ridgeway On German
715 South German Street
New Ulm, MN56073
Brown County, 08

Establishment Info:
ID #: 0039185
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073547400
ID #:

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

The following orders previously issued on 10/04/22 have NOT been corrected.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Chlorine concentration in sanitizer bucket is exceeding 200ppm.

Issued on: 10/04/22 *Comply By: 10/04/22*

2-400 Hygenic Practices

2-402.11

MN Rule 4626.0115 Food employees must wear an effective hair restraint, such as a hat, hair covering or hair net, a beard restraint and clothing to keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.

Employees observed not wearing a hair restraint.

Issued on: 10/04/22 *Comply By: 10/04/22*

4-500 Equipment Maintenance and Operation

4-502.13

MN Rule 4626.0830 Discontinue re-use of any single-service and single-use articles.

Facility is reusing single use plastic containers to store food.

Issued on: 10/04/22 *Comply By: 10/04/22*

Type: Full
Date: *10/04/22*
Time: 09:00:00
Report: 1033221159
Ridgeway On German

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

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

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 1033221159 of 10/04/22.

Certified Food Protection Manager: Vincent G Branch

Certification Number: FM107259 Expires: 07/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Vincent G Branch

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