



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 3, 2025

Licensee

Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431

RE: Project Number(s) SL32649016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 may be 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(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 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: SL32649016 On May 12, 2025, through May 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 30 residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a staffing plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 470			

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0 470	Continued From page 2 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 held an assisted living license. The facility was licensed for a capacity of 66 and had a current census of 30 residents. On May 12, 2025, at 9:55 a.m., during the entrance conference licensed assisted living director/register nurse (LALD/RN)-A stated a staffing plan had been developed and the staffing plan was evaluated at least twice yearly. LALD/RN-A stated the daily staff scheduled was: - two or three unlicensed personnel (ULP) worked from 6:00 a.m. until 2:30 p.m. LALD/RN-A stated there could be two ULP on the floor and one ULP scheduled as bath aide - two or three ULP worked from 2:00 p.m. until 10:30 p.m. - two ULP worked from 10:15 p.m. until 6:15 a.m. On May 12, 2025, at 11:58 a.m., the surveyor reviewed the facility's staffing plans dated September 11, 2024, and March 12, 2025, respectively, and noted: unlicensed staff in each area per shift, daily: - a.m., (morning) shift: three - p.m., (afternoon) shift: three - NOC (night) shift: two. Licensed staff per day: - a.m., weekdays 0.5 (shifts worked per pay period), CNS (clinical nurse supervisor), RN 1.4, LPN (licensed practical nurse) one - p.m., one RN on call, one LPN on call - a.m., weekends, one RN on call, one LPN on call	0 470			

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0 470	Continued From page 3 - p.m., weekends, one RN on call, one LPN on call. "Comments", blank. On May 12, 2025, at 12:08 p.m., LALD/RN-A stated the surveyor should talk to clinical nurse supervisor (CNS)-C about the facility's staffing plan. On May 12, 2025, at 12:15 p.m., CNS-C stated she just looked at it (staffing plan) and the list of "things" ("call response, etc."). CNS-C stated there was nothing in writing (no metric) used determine the staffing plan. CNS-C stated it made sense to why a metric should be used to determine staffing needs. On May 13, 2025, at 11:40 a.m., the surveyor observed ULP-F ask ULP-J, in the medication room, how the resident in room 208 was? ULP-F stated she (ULP-F) was a bath aide this day, but she (ULP-F) was also trained and gave medications. ULP-F stated she "did it all (tasks at the facility)." The surveyor observed ULP-I on a medication cart, ULP-J on a medication cart, and ULP-K on a medication cart this a.m. shift (three medication passers and a bath aide working). The licensee's Direct Care Staffing Plan undated template noted "facility name" is a Minnesota licensed Assisted Living with Dementia Care community. This facility does have two secured Dementia Care units. We have the ability to service up to (census) residents. The CNS develops and is accountable for the implementation of our staffing plan. The staffing plan will be reviewed, at a minimum, two times each year. Goal and Objectives: to provide an adequate number of qualified direct-care staff to meet our	0 470			

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0 470	Continued From page 4 resident's needs 24 hours a day, seven days a week. To ensure staffing levels are adequate to address: - each resident's needs as identified in the resident's service plan and assisted living contract - each resident's acuity level is determined by the most recent assessments - staff will meet the resident's scheduled and reasonably foreseen unscheduled needs, given the physical layout of the facility, in a timely manner - ability to respond promptly to individual resident emergencies and disaster situation. Staffing Plan: - staff has the required experience, training, and competency to provide care and services provide to residents as appropriate for their position - ULP staff receive the required orientation and annual training and competency evaluation per our training policy - ULP staff receive the additional training and competency evaluation for additional nurse-delegated tasks as needed abased upon the resident service plan, assessment, and/or evaluation - licensed nursing staff have a valid license to practice in Minnesota - licensed nursing staff receive the required orientation and annual training per our training policy - when residents require two-person assistance, there will be a minimum of two staff available at all times - there will be 24-hour, awake staff available to respond to resident needs within a reasonable amount of time if necessary, the facility will contract with supplemental staffing agencies to ensure adequate staff coverage	0 470			

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0 470	Continued From page 5 - there is a RN available to unlicensed staff 24 hours a day, seven days a week - adequate number of staff is determined by reviewing the number and acuity of each resident. This information will be generated from the electronic health record - the staffing schedules and daily posting will reflect the determination of what is needed for an adequate number of staff. The licensee's Staffing & Scheduling policy dated August 1, 2021, noted the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, Seven-days a week - the clinical nurse supervisor must ensure that staffing levels area adequate to address the following: - each resident's needs, as identified in the resident's service plan and assisted living contract - each resident's acuity level, as determined by the most recent assessment or individualized review - the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises - weather the facility as a secured dementia care unit - staff experience, training, and competency. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs an according to an up-to-date service plan subject to accepted health care	0 470			

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0 470	Continued From page 6 standards. Residents have the right to receive health care and other assisted living services in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of	0 480			

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0 480	Continued From page 7 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 480			

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0 480	Continued From page 8 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650			

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0 650	Continued From page 9 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of three employees (unlicensed personnel (ULP)-I), registered nurse (RN)-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 12, 2025, at 9:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents of employee records. ULP-I ULP-I was hired on July 16, 2024, to provide direct care services to the facility's residents. On May 13, 2025, at 7:30 a.m., the surveyor observed ULP-I apply gloves, ask R5 which finger he (R5) would like tested. ULP-I cleaned the ring finger on R5's left hand, ULP-I used a lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood). ULP-I used	0 650			

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0 650	Continued From page 10 correct technique to obtain a blood glucose reading of 259. ULP-I stated R5 had had a different blood glucose testing system (Dexcom or Libre blood sugar system [measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm]. ULP-I stated that R5's (blood glucose testing/Dexcom) system was currently "broken." ULP-I's employee record included training for the following topics, dated July 16, 2024, blood sugar checks: - wash hands, put on gloves - turn on glucose meter - prepare meter by validating the proper code with strips to be used - select finger and clean with alcohol pad or have resident wash hands with soap and water - pricks resident finger lateral to the fingertip using lance type device obtaining a large hanging drop blood - applied blood to test strip - allows blood to remain on strip until result appears on meter - covers lance finger with gauze/tissue until bleeding stops - dispose of lancet in red sharps container - remove gloves, wash hands - documents as appropriate - verbalize actions to take if a malfunction. ULP-I's employee record did not include documentation of training and competency for Dexcom/Libra blood glucose testing system. On May 14, 2025, at 8:26 a.m., LALD/RN-A stated, "we" (licensee) show ULP how, and added, I (LALD/RN-A) "bet we" (licensee) don't document the ULP training and competency on Dexcom/Libra glucose testing system, in	0 650			

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0 650	Continued From page 11 employee records. On May 14, 2025, at 10:31 a.m., LALD/RN-A told RN-L that training and competency for Dexcom/Libre blood glucose monitoring would need to be added to the ULP training documentation. RN-L stated she trained ULP on "that" (Dexcom/Libre) system but stated there was no documentation of the training in ULPs records. RN-L RN-L was hired on March 15, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On May 13, 2025, at 11:22 a.m., the surveyor observed RN-L go into R12's room and remove a Refresh eye solution container (dry eyes) which was positioned on a side table. RN-L's employee record lacked to include an annual performance review that identify areas of improvement needed and training needs. On May 14, 2025, at 9:45 a.m., LALD/RN-A stated she had not completed a written annual perform review for RN-L. LALD/RN-A added "I know what she (RN-L) does and do I (LALD/RN-A) watch her? yes." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic:	0 650			

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0 650	Continued From page 12 (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Training Records policy dated August 1, 2021, noted the (name of licensee) would maintain a record of staff straining and competency required. The licensee would document the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number - name of the training topic or thing program - the training methodology, such as classroom style, web-based tracing, video, or one-to-one training - date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation - name the title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluators' signature with a	0 650			

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0 650	Continued From page 13 statement attesting that the employee successfully compete the training and competency evaluation, and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation - documentation of the completed competency evaluation, training, retraining, or orientation would be provided to the employee at the time the evaluation or training was completed. The licensee's Employee Evaluation policy dated August 1, 2021, noted all staff of the (name of licensee) would be given an employee evaluation at least annually original signed form was placed in the employee's personnel file and a copy of the competed and signed form would be given to the employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 14 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: POSTED IN PROMINENT AREA On May 12, 2025, at 10:00 a.m., during the entrance conference licensed assisted living	0 680			

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0 680	Continued From page 15 director/registered nurse (LALD/RN)-A stated the facility's EPP (main binder) was located in her (LALD/RN-A's) office. LALD/RN-A stated her office was locked when she was not present. LALD/RN-A stated she was not sure if there was a sign that noted where the facility's EPP was located in the commons area. LALD/RN-A stated the EPP was last reviewed within the last two to three months. On May 12, 2025, at 10:07 a.m., during a tour of the facility with LALD/RN-A the surveyor and LALD/RN-A did not observed any signage of the facility's EPP plans location. LALD/RN-A confirmed the EPP was not posted in a prominent area as required. CONTENT On May 12, 2025, at 1:52 p.m., the surveyor reviewed the facility's EPP dated February 27, 2025, with LALD/RN-A. The facility's EPP did not include: - identification of the at-risk population. On May 12, 2025, at 1:56 p.m., LALD/RN-A stated the facility's EPP did not contain the population at risk. LALD/RN-A stated the population at risk was identified in the computer but not in the EPP as required, nor did the facility's EPP note where the at-risk population could be found. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, noted the (name of) management would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS (Centers for Medicare & Medicaid Services) Appendix Z. The policy noted	0 680			

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0 680	Continued From page 16 the Emergency Disaster Plan can be found in the Executive Director office and Nurse's office. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, noted the emergency preparedness plan included policies and procedures designed to align with the LTC (long term care) requirements in Appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775			

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0 775	Continued From page 17 failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 13, 2025, from 10:15 a.m. to 12:00 p.m., with maintenance worker (MW)-D, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT ACCESS DOOR LOCKING There was bolt style lock hardware installed on the exterior of the first-floor laundry room door that was only operable from the outside of the door and not operable from the inside of the room in order to exit the space in the event of a fire or similar emergency. There was a padlock hasp lock hardware installed on the exterior of the walk-in cooler and freezer room door that was only operable from the outside of the door and not operable from the inside of the room in order to exit the space in the event of a fire or similar emergency. It was explained that all rooms and spaces are required to be provided with locking hardware that	0 775			

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0 775	Continued From page 18 is operable from inside the room without the use of keys, tools or special knowledge in order to release the door to exit the space in the event of a fire or similar emergency. FIRE SPRINKLER SYSTEM MAINTENANCE The recent fire sprinkler inspection report dated March 27, 2025, indicated the dry system riser and air maintenance system was rusting and requires repair. The same fire sprinkler inspection report indicated the main feed requires repair. During an interview on May 13, 2025, at 11:45 a.m. licensed assisted living director/ registered nurse (LALD/RN)-A, stated the work to repair the deficiencies indicated on the fire sprinkler inspection report will be scheduled with a vendor to complete the repairs. COMMERCIAL KITCHEN EXHAUST HOOD AND DUCT CLEANING During the tour, documentation of commercial kitchen exhaust hood cleaning was requested. During an interview on May 13, 2025, at 10:35 a.m., MW-D, stated there was not documentation available indicating the commercial kitchen exhaust hood and duct system were inspected or cleaned as required by MSFC in Minnesota Rules Chapter 7511. COMMERCIAL KITCHEN COOKING EQUIPMENT FIRE PROTECTION During the tour it was observed the inspection/ service tag on the fire suppression system protecting the commercial kitchen cooking equipment was dated March 8, 2023.	0 775			

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0 775	Continued From page 19 During an interview on May 13, 2025, at 10:40 a.m., MW-D, stated there was not current documentation available indicating the commercial kitchen cooking equipment fire suppression system was inspected and serviced as required by MSFC in Minnesota Rules Chapter 7511. FIRE ALARM SYSTEM MAINTENANCE During the tour and an interview on May 13, 2025, 11:50 a.m., documentation was requested to indicate the building fire alarm system was inspected and serviced annually as required. During the interview LALD/RN-A, and MW-D, stated documentation was not available indicating the building fire alarm system was inspected and serviced annually as required and they would send the documentation by email. No further information was provided. FIRE RESISTANT RATED DOOR MAINTENANCE During the tour the fire-resistant rated doors at the first and third floor of the exit stairway near the commercial kitchen were tested for operation and did not close and positively latch automatically. It was explained to MW-D, that required fire resistant rated doors in exit stairs shall automatically close and positively latch to protect from smoke and fire from entering the stair in the event of a fire or similar emergency. During the facility tour MW-D, and LALD/RN-A, verified the above listed observations while	0 775			

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0 775	Continued From page 20 accompanying on the tour. TIME PERIOD FOR CORRECTION: seven (7) days.	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms in the facility. This had the potential to affect a limited	0 780			

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0 780	Continued From page 21 number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: SMOKE ALARM INTERCONNECTION On a facility tour on May 13, 2025, from 10:15 a.m. to 12:00 p.m., with maintenance worker (MW)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in the bedrooms and outside the bedrooms in resident sleeping unit 218. All sleeping units are required to be provided with smoke alarms that are interconnected within the sleeping unit. During the tour MW-D, verified the smoke alarms in resident sleeping unit 218 were not interconnected. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	0 790			

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0 790	Continued From page 22 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on May 13, 2025, from 10:15 a.m. to 12:00 p.m., with maintenance worker (MW)-D, it was observed that the required fire extinguishers were last serviced in March of 2024. It was explained that provided fire extinguishers are required to be annually serviced in accordance with Minnesota State Fire Code in Minnesota Rules Chapter 7511. During the facility tour MW-D, verified the above listed observations while accompanying on the	0 790			

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0 790	Continued From page 23 tour and stated they contacted the vendor to get on the list to compete the required annual service. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			
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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill	0 810			

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0 810	Continued From page 24 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 13, 2025, at 9:15 a.m., licensed assisted living director/ registered nurse (LALD/RN)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location and number of resident sleeping rooms were not identified for the complete floor	0 810			

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
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0 810	Continued From page 25 where the posted FSEP evacuation floor plans were located on each floor. Each FSEP evacuation plan that was posted was partial plan and did not indicate the locations of all resident rooms. It was explained to LALD/RN-A, that resident sleeping room numbers are required to be included on the evacuation floor plan and the floor plan of the entire floor shall be included at each posted location in order to direct building occupants to the required exits in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on May 13, 2025, at 9:15 a.m., LALD/RN-A, and maintenance worker (MW)-D, stated the FSEP floor plans posted throughout the building were not complete plans for the entire floor and did not include all resident rooms for each floor. During the same interview LALD/RN-A, and MW-D, stated they would revise the posted FSEP floor plans to include the entire floor and all resident rooms for each floor. During the same interview LALD/RN-A, and MW-D, also stated the resident procedures required in the event of a fire or similar emergency were not included in writing and available in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation employees	0 810			

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0 810	Continued From page 26 were trained at hire, but the evacuation drills were considered as training for the required bi-annual training. It was explained to LALD/RN-A, that the employee training based on the FSEP and fire evacuation drills shall be completed and documented as separate events. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation resident training based on the FSEP was provided annually. During an interview on May 13, 2025, at 9:30 a.m., LALD/RN-A, stated documentation was not available indicating residents were provided training based on the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290			

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01290	Continued From page 27 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID 32649) for three of 38 employees (unlicensed personnel (ULP)-F, ULP-G, activities director (AD)-E). This had the potential to affect all 30 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 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: During the entrance conference on May 12, 2025, at 9:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents of employee records. ULP-F ULP-F was hired on April 13, 2021, to provide direct care services to residents of the facility.	01290			

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01290	Continued From page 28 On May 13, 2025, at 11:40 a.m., the surveyor observed ULP-F ask ULP-J, in the medication room, how the resident in room 208 was? ULP-F stated she (ULP-F) was a bath aide this day, but she (ULP-F) was also trained and gave medications. ULP-F stated she "did it all (tasks at the facility)." ULP-F's employee record included a background study dated October 8, 2021, for HFID 33942. ULP-F's employee record lacked documentation of a cleared background study for HFID 32649. ULP-G ULP-G was hired on March 27, 2023, to provide direct care services to residents of the facility. R6's medication administration record (MAR) dated May 1, 2025, through May 13, 2025, indicated ULP-G administered R6's A & D ointment (skin protection) and Nystatin 100,000 units/ gram powder (yeast) on May 2, 2025, at 10:30 a.m. ULP-G's employee record included a background study dated February 9, 2023, for HFID 33942. ULP-G's employee record lacked documentation of a cleared background study for HFID 32649. AD-E AD-E was hired on August 28, 2017, as the activities director. On May 13, 2025, at 11:22 a.m., the surveyor observed AD-E facilitating a game of kick ball with 16 residents in the common's area. AD-E's employee record included a background	01290			

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01290	Continued From page 29 study for dated October 5, 2021, for HFID 33942. AD-E' s employee record lacked documentation of a cleared background study for HFID 32649. On May 12, 2025, at 12:27 p.m., LALD/RN-A confirmed ULP-F, ULP-G and AD-E's background studies did not include the correct HFID number. LALD/RN-A stated she was not sure why/what happened regarding the background studies noted above, why they were not affiliated with HFID 32649. LALD/RN-A stated that was prior to her time completing background studies at the facility. LALD/RN-A stated she would need to look not only at the name of the facility but the HFID number going forward. The licensee's Background Studies policy dated August 1, 2021, noted no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The licensee would not employ individuals whose results of the background study indicated disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500			

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01500	Continued From page 30 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500			

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01500	Continued From page 31 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for two of three employees (registered nurse (RN)-L, clinical nurse supervisor (CNS)-C). 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: RN-L RN-L was hired on March 15, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On May 13, 2025, at 11:22 a.m., the surveyor	01500			

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01500	Continued From page 32 observed RN-L go into R12's room and remove a Refresh eye solution container (dry eyes) that was positioned on a side table. RN-L's employee record lacked evidence RN-L successfully completed annual training as required to include: - training on reporting of maltreatment of vulnerable adults - review of the assisted living bill of rights - review of infection control techniques - review of the facility's policies and procedures - effective approaches to use to problem solve when working with challenging behaviors - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - a minimum of eight hours of training per 12 months of employment. On May 14, 2025, at 9:31 a.m., RN-L's employee training transcript was reviewed with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A confirmed RN-L's transcript did not include any completed classes for 2024. LALD/RN-A stated all the required training modules had been assigned to RN-L however RN-L had not completed any of the training assigned, as required. On May 14, 2025, at 10:36 a.m., RN-L stated she had two jobs had not completed the required annual training as required. CNS-C CNS-C was hired on October 10, 2023, as the CNS for the facility, to provide direct care and services to the licensee's residents and oversight of the licensee's employees.	01500			

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01500	Continued From page 33 On May 12, 2025, at 12:15 p.m., the surveyor reviewed the facility's staffing plan with CNS-C. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 15, 2025, at 8:12 a.m., the surveyor received an email from executive director/owner (ED/O)-M that noted the licensee was unable to locate evidence that CNS-C completed the principles of person-centered planning and service delivery for annual training as required. The licensee's Annual Required Staff Training policy dated August 1, 2021, noted all staff that perform direct care services will complete at least eight hours of annual training for each 12 months of employment. The following training elements must be included every 12 months to all staff who performed direct care services: - training on reporting of maltreatment of vulnerable adults under section 626.557 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and the use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases - effective approaches to use to problem solve	01500			

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01500	Continued From page 34 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01530			

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01530	Continued From page 35 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three employees (registered nurse (RN)-L), received the required two hours of dementia care annual training. 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: RN-L was hired on March 15, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On May 13, 2025, at 11:22 a.m., the surveyor observed RN-L go into R12's room and remove a Refresh eye solution (dry eye) container that was positioned on a side table. RN-L's employee record lacked evidence two hours of annual dementia training was completed	01530			

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01530	Continued From page 36 in 2024. On May 14, 2025, at 9:31 a.m., RN-L's employee training transcript was reviewed with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A confirmed RN-L's transcript did not include any completed dementia classes for 2024. LALD/RN-A stated the required training modules had been assigned to RN-L however RN-L had not completed the training assigned, as required. On May 14, 2025, at 10:36 a.m., RN-L stated she had two jobs and had not completed the required annual training as required. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of the licensee are required to complete dementia training at the time of hire and annually thereafter. All staff would complete two hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640			

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01640	Continued From page 37 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 12, 2025, at 9:45 a.m., licensed assisted living director/ registered nurse (LALD/RN)-A stated she (LALD/RN-A) and RN's (CNS-C, RN-L) update the services plans "for the most part." LALD/RN-A added "nurses are involved."	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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
01640	Continued From page 38 R5's diagnoses included morbid obesity, chronic venous ulcers (crater-like open sores on the skin) of lower extremities, chronic abdominal wall ulcers, lymph edema (build-up of lymph fluids in the fatty tissue of skin) of lower extremities, and diabetes. R5's service plan dated March 20, 2025, included wound care three days a week, LPN (licensed practical nurse). R5's treatment administration record (TAR) dated May 1, 2025, through May 12, 2025, included wound care: Monday, Tuesday, Wednesday, Thursday, Friday, authenticated by LPN-B. R5's prescriber order dated May 1, 2025, noted: -request from ALF (assisted living facility) for dressing changes to be completed M-F (Monday through Friday) as that is when they have skilled nursing available. Okay to chance dressing daily during the weekdays. Recommend changing Friday as late in the afternoon/evening as can and then first thing Monday morning. On May 13, 2025, at 5:48 a.m., the surveyor R5 lying in a hospital bed. The surveyor observed a large dressing coving R5's abdomen. The surveyor observed unlicensed personnel (ULP)-H use correct technique empty R5's catheter bag (urine collection bag). ULP-H washed R5's groin area and offered Nystatin powder (yeast) to R5. ULP-H stated the nurse does R5's "belly" (wound care/ dressing change). R5's service plan was not revised as required, to include wound care Monday through Friday. On May 13, 2025, at 1:56 p.m., the surveyor reviewed R5's service plan with LALD/RN-A and	01640			

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01640	Continued From page 39 LPN-B. LPN-B stated she was not able to update service plans. LALD/RN-A stated R5's service plan not revised to reflect current services as required. The licensee's Service Plan Modifications policy dated August 1, 2021, noted when a resident at the (name of facility) received assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; 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 observation, interview and record review, the licensee failed to provide specific resident instructions relating to the administration	01750			

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01750	Continued From page 40 of medications for two of two residents (R9, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R9 R9's diagnoses included diabetes, and diabetic neuropathy (numbness, prickling, tingling, lack of feeling, weakness). R9's service plan dated March 20, 2025, included medication administration five times daily. R9's medication administration record (MAR) dated May 1, 2025, though May 12, 2025, included: Humalog (short acting insulin/diabetes) 100 units/milliliter (ml) Kwikpen, inject four units into the skin three times daily with meals. If patient skips a meal do not give insulin: plus, correction 0-5 units per sliding scale, maximum 27 units per day Humalog 100 units/ ml Kwikpen: given additional units based on this scale. Notify registered nurse (RN) if blood sugar is below 70 or above 350 - blood sugar 200 or less = 0 units - blood sugar 201-250 = 1 units - blood sugar 251-300 = 2 units - blood sugar 301- 450 = 3 units - blood sugar 351- 400 = 4 units, notify RN - blood sugar 401- 450 = 5 units, notify RN - blood sugar 451 or above notify RN.	01750			

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01750	Continued From page 41 Toujeo Solostar (long-acting insulin) 300 units/ml, inject 16 units under the skin at bedtime. R9's prescriber's order dated February 8, 2025, included the above orders. On May 13, 2025, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-I use correct technique and inject five units of Humalog insulin into R9 left upper abdomen site. On May 13, 2025, at 7:38 a.m., the surveyor observed ULP-I inject one unit of Humalog insulin into R9's upper left abdomen site. Directly after the above observation the surveyor reviewed R9's record with ULP-I. ULP-I stated R9's record did not include any direction for documenting of insulin injection site used. R5 R5's diagnoses included morbid obesity, chronic venous ulcers (crater-like open sores on the skin) of lower extremities, chronic abdominal wall ulcers, lymph edema (build-up of lymph fluids in the fatty tissue of skin) of lower extremities, and diabetes. R5's service plan dated March 20, 2025, included medication administration seven times daily (ULP), and one day a week by LPN (licensed practical nurse). R5's MAR dated May 1, 2025, through May 12, 2025, included Ozempic (weight lost/diabetes) 2 milligrams (mg) Wednesday, inject 2 mg subcutaneously once weekly. R5's prescriber order dated May 1, 2025, included the above order.	01750			

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01750	Continued From page 42 On May 13, 2025, at 5:48 a.m., the surveyor R5 lying in a hospital bed. The surveyor observed a large dressing coving R5's abdomen. The surveyor observed ULP- H use correct technique empty R5's catheter bag (urine collection bag). On May 13, 2025, at 12:54 p.m., R9's record was reviewed with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated R9's record did not include directions for documentation for insulin injection sites. On May 14, 2025, at 10:39 a.m., LPN-B stated she was not aware that insulin injection sites needed to be documented. LPN-B stated most of the times she documents where she injected R5's Ozempic, but not always. LPN-B stated there were no instructions in any of the resident's record to review previous injection site used for prior to insulin injection and to document injection site. LPN-B and LALD/RN-A asked about Ozempic, as it was a weekly medication. The manufacturer's instructions for Ozempic were reviewed with them (LPN-B, LALD/RN-A). LPN-B confirmed resident records did not include specific resident instructions for insulin administration as required. The manufacturer's instructions for Humalog Kwikpen dated June 2022, noted change (rotate) injection sites within the area of choice for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. The manufacturer's instructions for Toujeo dated October 2022, noted change (rotate) injection	01750			

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01750	Continued From page 43 sites within the area choose for each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The manufacturer's instructions for Ozempic dated July 2024, noted administer Ozempic once weekly, on the same day each week, at any time of the day, with or without meals. Inject Ozempic subcutaneous to the abdomen, thigh, or upper arm. Instruct patient to use a different injection site each week when injecting in the same body region. When using Ozempic with insulin, instruct patients to administer as separate injections and to never mix the products. It is acceptable to inject Ozempic and insulin in the same body location, but the injections should not be adjacent to each other. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, noted a RN may delegate nursing services to a person who had successfully competed staff orientation, who had been trained in the service to be provided and who had demonstrated the RN the ability to competently follow the procedures for the resident. These services included: performing medications management services, medications reminders, assistance, or administration. When medication management was delegated to a ULP, the RN would: - specify, in writing, specific instructions for the unlicensed personnel about the individual needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			

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01760	Continued From page 44	01760			
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 one of two unlicensed personnel (ULP)-I followed registered nurse (RN) written instructions for one of two residents (R9). Additionally, the licensee failed to ensure medications were administered as ordered for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01760			

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01760	Continued From page 45 The findings include: WRITTEN INSTRUCTIONS R9 R9's diagnoses included diabetes, and diabetic neuropathy (numbness, prickling, tingling, lack of feeling, weakness). R9's service plan dated March 20, 2025, included medication administration five times daily. R9's medication administration record (MAR) dated May 1, 2025, though May 12, 2025, included: Humalog (short acting insulin) 100 units/milliliter (ml) Kwikpen, inject 4 units into the skin three times daily with meals if patient skips a meal do not give insulin: plus, correction 0-5 units per sliding scale, maximum 27 units per day Humalog 100 units/ ml Kwikpen: given additional units based on this scale. Notify registered nurse (RN) if blood sugar is below 70 or above 350 - blood sugar 200 or less = 0 units - blood sugar 201-250 = 1 units - blood sugar 251-300 = 2 units - blood sugar 301- 450 = 3 units - blood sugar 351- 400 = 4 units, notify RN - blood sugar 401- 450 = 5 units, notify RN - blood sugar 451 or above notify RN. On May 13, 2025, at 7:30 a.m., the surveyor observed ULP-I apply gloves, ask R5 which finger he (R5) would like tested. ULP-I cleaned the ring finger on R5's left hand, ULP-I used a lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood). ULP-I used correct technique to obtain a blood glucose reading of 259. On May 13, 2025, at 7:32 a.m., the surveyor	01760			

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01760	Continued From page 46 observed ULP-I use correct technique and inject five units of Humalog insulin into R9 left upper abdomen site. Directly after the above observation the surveyor reviewed R9's MAR with ULP-I to include R9's Humalog sliding scale. R9's blood sugar had been 259. ULP-I stated R9 should have received two units of insulin, not one unit, for a total of six units of Humalog. On May 13, 2025, at 7:38 a.m., the surveyor observed ULP-I inject one unit of Humalog insulin into R9's upper left abdomen site. On May 13, 2025, at 1:25 p.m., the surveyor reviewed R9's record with licensed assisted living director/ registered nurse (LALD/RN)-A. LALD/RN-A stated ULP-I "told on herself (incorrect insulin administered)" LALD/RN-A confirmed directions in the R9's MAR were to be followed. ADMINISTERED AS ORDERED R5 R5's diagnoses included morbid obesity, chronic venous ulcers (crater-like open sores on the skin) of lower extremities, chronic abdominal wall ulcers, lymph edema (build-up of lymph fluids in the fatty tissue of skin) of lower extremities, and diabetes. R5's service plan dated March 20, 2025, included medication administration seven times daily. R5's prescriber order dated May 1, 2025, included: -apply calmoseptine (topical ointment that contains menthol (peppermint/cooling) and zinc oxide (zinc is insoluble in water/skin protectant)	01760			

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01760	Continued From page 47 moisture barrier) to scrotum/buttock, daily -apply small piece Aquacel Extra (absorbent dressing for moderate to highly exuding (discharge) wounds) as needed (PRN) to open sore of scrotum. R5's medication administration record (MAR) dated May 1, 2025, through May 12, 2025, included: - A & D ointment (vitamins A and D in topical ointment used for skin protectant, works by monitoring and clearing the skin) please administer to groin twice daily to prevent skin breakdown (start date May 9, 2024) R5's MAR did not include calmoseptine. On May 14, 2025, at approximately 9:30 a.m., LALD/RN-A stated on second look it was possible to read the order for calmoseptine as a PRN order, not a medication error. R5's MAR was reviewed, calmoseptine was not on R5's MAR as a PRN order. LPN-B stated she did not see the order for calmoseptine, and it had not been added to R5's MAR for administration. The licensee's Insulin policy dated August 1, 2021, noted medications always need to be administered according to the "6 Rights" - right person - right medications - right time - right route (i.e. by moth, eye drop, to the skin) - right dose (i.e., how many milligrams, drops) - right chart/record to document that the medications was taken Compare the information of the MAR with the label on the medication container. The following information should be in all the places: - resident name	01760			

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01760	Continued From page 48 - name of the medication - the strength and dosage of the medication - the route - the time that the medication was to be given - any special instructions Read the label and compare it with the information on the MAR three times to make sure that you haven't made a mistake. The licensee's Medication & Treatment Orders-Implementing dated August 1, 2021, noted upon receipt of a medication and/or treatment orders, whether new or changed on an order from an authorized prescriber, a licensed nurse must take action to implement that order within 24 hours. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, noted a RN may delegate nursing services to a person who had successfully completed staff orientation, who had been trained in the service to be provided and who had demonstrated the RN the ability to competently follow the procedures for the resident. These services included: performing medications management services, medications reminders, assistance, or administration. When medication management was delegated to a ULP, the RN would: -instruct the unlicensed personnel in the proper methods to administer the medication -verify the unlicensed personnel had demonstrated the ability to competency follow the procedures - specify, in writing, specific instructions for the unlicensed personnel about the individual needs of the resident -communicate with the unlicensed personnel about the individual needs of the resident.	01760			

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01760	Continued From page 49 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored during the medication administration process by two of four unlicensed personnel (ULP-H, ULP-I). 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: MEDICATION IN ROOM R5's diagnoses included morbid obesity, chronic venous ulcers (crater-like open sores on the skin) of lower extremities, chronic abdominal wall ulcers, lymph edema (build-up of lymph fluids in	01880			

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01880	Continued From page 50 the fatty tissue of skin) of lower extremities, and diabetes. R5's service plan dated March 20, 2025, included medication administration seven times daily (ULP) and one day a week by LPN (licensed practical nurse). R5's medication administration record (MAR) dated May 1, 2025, though May 13, 2025, included: -Nystatin 100,000 unit/grams powder daily, apply topically to the affected area, three times daily. R5's prescriber order dated May 1, 2025, included the above order. R5's Individualized Medication Management Plan dated April 30, 2025, noted: -all medication kept in medication cart, staff have the keys -all medications are stored in medication carts. Carts are locked when staff are not in attendance of the cart. On May 13, 2025, at 5:48 a.m., the surveyor R5 lying in a hospital bed. The surveyor observed ULP- H use correct technique empty R5's catheter bag (urine collection bag). ULP-H washed R5's groin area and offered Nystatin powder (yeast) to R5. R5 declined the use of Nystatin powder. On May 13, 2025, at 6:16 a.m., the surveyor observed ULP-H exit R5's room. The surveyor did not observe ULP-H remove R5's Nystatin powder from R5's room. On May 13, 2025, at 6:26 a.m., ULP-H stated leaving the Nystatin powder in R5's room was not	01880			

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01880	Continued From page 51 the "normal." ULP-H thanked the surveyor for the "reminder" (to remove the Nystatin powder). ULP-H removed the Nystatin from R5's room. On May 13, 2025, at approximately 10:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated, "it happens" (ULPs forget powder in room). LALD/RN-A stated then the ULP has to go back and get the powder. LALD/RN-A confirmed R5's Nystatin powder should be stored in the secured medication cart. MEDICATION CART On May 13, 2025, at 7:12 a.m., the surveyor observed on the third floor of the facility an unsecured medication cart. The surveyor did not observe any staff on the third floor. The surveyor observed approximately 12 doors to resident's rooms, at least one door was open. On May 13, 2025, at 7:15 a.m., the surveyor heard the elevator sound, water being ran, and towels pulled. The surveyor looked around a corner and observed ULP-I in the laundry room/ next to the elevator. Directly after the above observation ULP-I stated she "screwed up." ULP-I stated the medication cart was to be secured when not in use. ULP-I confirmed the medication cart had been left unsecured when she (ULP-I) left the third floor. On May 13, 2025, at 7:17 a.m., the surveyor observed ULP-I tell licensed practical nurse (LPN)-B she made a mistake, left the medication cart unsecured. On May 13, 2025, at 7:41 a.m., the surveyor observed R3 wandering the hall on the third floor.	01880			

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01880	Continued From page 52 On May 13, 2025, at 1:25 p.m., licensed assisted living director /registered nurse (LALD/RN)-A stated ULP-I "told on herself." LALD/RN-A confirmed the medication carts were to be secured when not in use. LALD/RN-A stated ULP-I was very nervous. The licensee's Medications Storage policy dated August 1, 2021, noted medications would be stored consistent with each resident's medication management plan and service plan. Medication managed by the licensee would be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft or illegal or improper dispositions of medications managed outside of a reinserts private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890			

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01890	Continued From page 53 review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for three of three medication carts (cart one, cart two, cart three). In addition, the licensee failed to monitor for expired medication for one of ten residents (R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 12, 2025, at 10:14 a.m., the surveyor, licensed assisted living director/registered nurse (LALD/RN)-A, and licensed practical nurse (LPN)-B reviewed the contents of the locked medication carts. LALD/RN-A and LPN-B observed and confirmed the following: CART ONE LEGIBLE AND COMPLETE INFORMATION - opened container of triamcinolone acetonide cream 0.1% (allergies, rheumatic (auto-immune) disorders, certain skin diseases) for R8, label un-legible and incomplete (could only read R8's last name written on the lid of the container with black marker). LPN-B stated R8 got his medications for the V. A. (veterans administration). LPN-B stated the label on R8's cream needed to be replaced.	01890			

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01890	Continued From page 54 CART TWO - opened Systane (dry eyes, without preservatives) lacked on open or an expiration date for R4. EXPIRED MEDICATION - opened TUMS (heartburn) container for R13 expiration date March 2025. CART THREE - opened Trelegy Ellipta inhaler (asthma) for R2 dated April 20, 2025, lacked an expiration date - opened Refresh (dry eyes) solution for R3 dated April 15, 2026, lacked an expiration date. Directly after the above observed LALD/RN-A stated R2's Trelegy was used daily and would be used up prior to the expiration date. LALD/RN-A added time sensitive medications require both an open and an expiration date. LPN-B removed R13's expired TUMS from medication cart two. The manufacturer's instructions for Systane dated 2022, noted Systane can be used for three months after opening. Always check the label for the expiration date. The manufacturer's instructions for Trelegy dated January 14, 2024, noted discard Trelegy Ellipta six weeks after you have taken it out of the foil pouch, or if the dose indicator shows a zero, whichever comes first. The manufacturer's instructions for Refresh dated June 2022, noted discard 90 days after opening. The licensee's Medications Storage policy dated August 1, 2021, noted when medications were managed and stored by the licensee, medications would be kept securely locked and stored per	01890			

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01890	Continued From page 55 manufacturer's directions. Only authorized staff would have access to stored medications. Medications would be stored consistent with manufacturer's recommendations. The licensee's Topical Application of Ointment & Cream policy dated August 1, 2021, noted compare the information of the MAR (medication administration record) with the label on the medication container. The following information should be in all the places: - resident name - name of the medication - the strength and dosage of the medication - the route - the time that the medication was to be given - any special instructions - if you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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 or therapy is delegated or assigned to unlicensed	01950			

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01950	Continued From page 56 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 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) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R9) receiving treatments. 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: R9's diagnoses included diabetes, and diabetic neuropathy (numbness, prickling, tingling, lack of feeling, weakness). R9's service plan dated March 20, 2025, included blood glucose (sugar) monitoring, four times per day.	01950			

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01950	Continued From page 57 R9's record included: record blood sugar, active August 6, 2020: -estimated minutes: ten Instructions: using the Dexcom 6 reader [measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm] *press home button to turn on reader *record glucose reading *if Dexcom reader does not work or reading are out of range check with finger stick glucometer. R9's blood sugar log dated April 13, 2025, through May 13, 2025, included: - entries noted 117 opportunities of 117 opportunities - blood sugar readings ranged from 50- 516 Notes included: - April 14, 2025, 8:00 p.m., 279, needs new sensor, had to poke his finger - April 19, 2025, 5:00 p.m., 173, finger stick - April 23, 2025, 95, told him to go straight to lunch - April 25, 25, 5:00 p.m., 60, did not administer [insulin] and brought him a glass of orange juice and he ate a candy bar as well - May 1, 2025, 12:00 p.m., 392, no note - May 3, 2025, 8:00 a.m., 50, no note - May 9, 2025, 12:00 p.m., he refused - May 12:00 p.m., he skipped lunch - May 12:00 p.m., LOA (leave of absence) - May 11, 2025, 8:00 p.m., 516, no note. R9's MAR dated May 1, 2025, through May 12, 2025, included: Humalog (short acting insulin/diabetes) 100 units/milliliter (ml) Kwikpen, inject four units into the skin three times daily with meals. if patient skips a meal do not give insulin: plus, correction 0-5 units per sliding scale, maximum 27 units per	01950			

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01950	Continued From page 58 day Humalog 100 units/ ml Kwikpen: given additional units based on this scale. Notify registered nurse (RN) if blood sugar is below 70 or above 350 - blood sugar 200 or less = 0 units - blood sugar 201-250 = 1 unit - blood sugar 251-300 = 2 units - blood sugar 301- 450 = 3 units - blood sugar 351- 400 = 4 units, notify RN - blood sugar 401- 450 = 5 units, notify RN - blood sugar 451 or above notify RN. Toujeo Solostar (long-acting insulin) 300 units/ml, inject 16 units under the skin at bedtime. R9's prescriber's order dated February 8, 2025, included the above orders. On May 13, 2025, at 1:25 p.m., the surveyor reviewed R9's record with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated she could have sworn "it" (R9's record) included what and when to report to nursing in regards to R9's blood sugar readings. LALD/RN-A stated R9's record did not include specific instructions for R9's blood sugar monitoring. On May 14, 2025, at 10:43 a.m., LALD/RN-A and licensed practical nurse (LPN)-B stated blood sugar monitoring in resident's record had been corrected, in "universal service." LALD/RN-A instructed LPN-B to update records as needed to provide person centered care. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, noted unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks and any other	01950			

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01950	Continued From page 59 training or competency requirements within the licensed health professional's scope of practice relating to delegated assignment of tasks to unlicensed personnel. Performing routine delegated or nursing procedures, such as, use of glucometers, The health care professional would: - specify, in writing, specific instructions for the unlicensed personnel about the individual needs of the resident. - communicate with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of two residents (R2). 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	02310			

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02310	Continued From page 60 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 12, 2025, at 10:43 a.m., during a tour of the facility with licensed assisted living director/registered nurse (LALD/RN)-A the surveyor and LALD/RN-A observed one tall oxygen tank in R2's room unsecured, six tall oxygen tanks in a rack, one oxygen tank in a holder. LALD/RN-A stated R2 was not currently at the facility. LALD/RN-A placed the unsecured oxygen tank into the oxygen rack. LALD/RN-A stated all oxygen tanks were to be secured. The licensee's Oxygen policy dated August 1, 2021, noted oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320			

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02320	Continued From page 61 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards by one of one unlicensed personnel (ULP-K) during medication administration for two of three residents (R8, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-K was hired on November 9, 2023, to provide direct care services to the facility's residents. ULP-K's employee record included: - medication administration-routes, completed November 6, 2023 - medication administration overview, completed November 13, 2023 - medication administration competency,	02320			

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02320	Continued From page 62 completed November 13, 2023. On May 13, 2025, at 7:43 a.m., the surveyor observed ULP-K knock on R8's door. ULP-K opened R8's door and stated, "I have your meds (medication) here." ULP-K placed a lidded medication cup on R8's table and left R8's room. ULP-K applied sanitizer to ULP-K's hands. On May 13, 2025, at 7:44 a.m., ULP-K knocked on R11's door. ULP-K and R11 exchanged pleasantries. ULP-K removed a pre-filled lidded medication cup out of her pocket. ULP-K stated, "I have your medication here, can I watch you (R11)take them (medication)?" R11 stated she "promises" to take the medication. ULP-K left the medication cup with R11. ULP-K applied sanitizer to ULP-K's hands. On May 13, 2025, at 7:45 a.m., the surveyor observed ULP-K knock on R7's door. ULP-K told R7 "I'll bring you down and you (R7) can eat some breakfast" ULP-K placed R7's feet on the pedals of R7's wheelchair, turned off R7's TV, and pushed R7's wheelchair to the elevator. On May 13, 2025, at 7:48 a.m., ULP-K stated she had labeled R8 and R11's medication cups with their names. ULP-K added she knew "whose medications were whose medications". ULP-K stated the medication administration completion process observed by the surveyor for R8 and R11 was "not her norm (normal)." The surveyor asked ULP-K what the normal process was? ULP-K replied, "to do one, and do one." (prepare, administer, document, prepare, administer, document). On May 13, 2025, at 7:49 a.m., the surveyor observed ULP-K document R11's morning	02320			

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02320	Continued From page 63 medication as administered. On May 13, 2025, at 7:56 a.m. the surveyor observed ULP-K administer R7's morning medication using correct technique. On May 13, 2025, at 8:02 a.m., the surveyor observed ULP-K document R8's morning medication as administered. On May 13, 2025, at 11:01 a.m., the surveyor reviewed R8, and R11's medication assessments with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A stated staff are to administer R8 and R11's medication and watch R8 and R11 take their medications. LALD/RN-A stated ULP-K should have observed R8 and R11's medication administration. On May 14, 2025, at 10:47 a.m., LALD/RN-A, and RN-L stated ULP-K was not trained to administer medication "like that." LALD/RN-A stated they wondered why ULP-K administered R8, and R11's medication that way. LALD/RN-A and RN-L stated ULP-K had gone rouge during medication administration for R8 and R11. The Medication Management-Administration & Setup policy dated August 1, 2021, noted documentation of a medication reminder, medication assistance or medication administration would be completed immediately after that task had been performed. The licensee's Professional Competency template dated August 2021, noted: - I have a total commitment to provide the highest quality of care to those who seek my services - I shall strive to become and remain proficient in my work practices and the performance of my	02320			

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
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02320	Continued From page 64 functions - I shall act in accordance with the highest standards of professional integrity - I shall not attempt to perform duties outside the recognized scope of my knowledge and position - I shall maintain respect for and follow facility policies, procedures, and management decisions - I shall support the integrity and reputation of the facility. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02430 SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records.	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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
02430	Continued From page 65 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure resident's personal health and medical information was kept private by one of three unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 13, 2025, at 7:12 a.m., the surveyor observed, on the third floor of the facility, an opened lap top computer. The computer screen displayed R12's medication list and diet. The surveyor did not observe any staff on the third floor. The surveyor observed approximately 12 doors to resident's rooms, at least one door was open. On May 13, 2025, at 7:15 a.m., the surveyor heard the elevator sound, water being ran, and towels pulled. The surveyor looked around a corner and observed ULP-I in the laundry room/ next to the elevator. ULP-I stated she just returned to the third floor of the facility. Directly after the above observation ULP-I stated she "screwed up." ULP-I stated the computer should not have been left open with the screen	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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
02430	Continued From page 66 up, with R12's medication information visible/accessible. ULP-I confirmed the computer was left open and unsecured when ULP-I was not on the third floor of the facility. On May 13, 2025, at 7:26 a.m., the surveyor observed ULP-I push the medication cart with lap top computer positioned on the top of the medication cart to the end of the hallway and around the corner of the third floor of the facility. ULP-I reviewed R9's electronic medication record (EMAR) on the computer screen. ULP-I removed blood testing (glucose) supplies, Humalog (insulin) 100 units/ milliliter pen, alcohol pad and needle out of the medication cart. ULP-I locked the medication cart. The surveyor did not observed ULP-I close the computer screen. ULP-I went into R9's room, tested R9's blood glucose (used correct technique) and administered R9's insulin. On May 13, 2025, at 7:33 a.m., the surveyor observed ULP-I return to the medication cart. The computer screen was in the raised and open position. R12 was standing by the medication cart/computer screen as the surveyor and ULP-I approached the medication cart/computer. R12 asked ULP-I for chocolate. On May 13, 2025, at 7:37 a.m., ULP-I stated, "oh yeah, you are right (surveyor)." ULP-I stated the computer screen should have been closed/secured when she assisted R9. On May 13, 2025, at 1:25 p.m., licensed assisted living director /registered nurse (LALD/RN)-A stated ULP-I "told on herself." LALD/RN-A confirmed the computer screen was to be closed when not in use. LALD/RN-A stated ULP-I was very nervous.	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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
02430	Continued From page 67 On May 14, 2025, at approximately 10:50 a.m., LALD/RN-A and RN-L stated R12 liked "his" chocolate, and added, R12 knew chocolate was kept in the medication cart (would stand and wait by the medication cart). LALD/RN-A and RN-L confirmed the computer screen should have been closed/secured. The licensee's Resident Record-Confidentiality policy dated August 1, 2021, noted resident records would be kept confidential and locked in a secured area where only authorized staff of the facility had access to. All staff were responsible to make sure confidentiality is maintained for all resident records and information. No personal, financial, medical, or other information about the resident would be disclosed to any other person, except: - as may be required by law - to staff - to contractors of the facility - to another home care provider or inpatient facility that required information that is necessary for the provision of services - to person authorized in writing by the resident or resident's responsible person - to representatives of the Minnesota Department of Health authorized to survey or investigate home care providers. The licensee's Professional Competency template dated August 2021, noted: - I shall not disclose resident/tenant/client confidences to anyone, except required by law. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to have personal, financial, health, and medical information kept	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(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
02430	Continued From page 68 private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Rivers Edge Assisted Living
11 Minnesota Avenue S.
Aitkin, MN 56431
Aitkin County
Parcel:

Phone:

License Info

License: 38522

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1017251011
Inspection Type: Full - Single
Date: 5/12/2025 Time: 12:04:09 PM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

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

COMMENT: CHRISTINA PALAZUELOS HAS NOT SUBMITTED HER CFPM TO STATE. SUBMIT SERVE SAFE CREDENTIAL WITH CFPM APPLICATION FOR STATE ISSUED CFPM.

Comply By: 5/12/2025 Originally Issued On: 5/12/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

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

COMMENT: PROVIDE TEST KIT FOR CHLORINE (DISH MACHINE).

Comply By: 5/12/2025 Originally Issued On: 5/12/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-304.11B Priority Level: Priority 3 CFP#: 56

MN Rule 4626.1475B Design, install and operate all ventilation systems, furnaces, gas or oil-fired heaters, and water heaters according to Minnesota Rules chapters 1305, 1346, and 7511.

COMMENT: FIRE SUPPRESSION WAS LAST INSPECTED IN 2023, INSPECT YEARLY.

Comply By: 5/12/2025 Originally Issued On: 5/12/2025

Food & Beverage General Comment

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1017251011 from 5/12/2025

CHRISTINA PALAZUELOS
KITCHEN MANAGER

Nate Topp,
Public Health Sanitarian 2
320-223-7333
nate.topp@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F1017251011		Food Establishment Inspection Report		Page 1 of 1		
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		0	Date: 5/12/2025	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 12:04:09 PM	
		Score (optional)			Dur: 60 min	
Establishment: Rivers Edge Assisted Living		Address: 11 Minnesota Avenue S.		City/State: Aitkin, MN	Zip: 56431	Phone:
License/Permit #: 38522		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable						
Mark "X" in appropriate box for COS and/or R						
COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Supervision						
1	IN	Person in charge present, demonstrate knowledge and performs duties				
2	IN	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	N/O	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	IN	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
Compliance Status				COS	R	
Safe Food and Water						
30	IN	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	IN	Variance obtained for specialized processing methods				
Food Temperature Control						
33		Proper cooling methods used; adequate equipment for temperature control				
34	N/O	Plant food properly cooked for hot holding				
35	N/O	Approved thawing methods used				
36		Thermometers provided & accurate				
Food Identification						
37		Food properly labeled; original container				
Prevention of Food Contamination						
38		Insects, rodents, & animals not present; no unauthorized person				
39		Contamination prevented during food prep, storage, & display				
40		Personal cleanliness				
41		Wiping cloths: properly used & stored				
42		Washing fruits & vegetables				
Person in Charge (signature)						
Inspector (signature)						
Follow-up: Follow-up Date:						
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury						