Electronically Delivered

July 13, 2022

Administrator
Ridgeway On 23rd
720 23rd Street North
New Ulm, MN 56073

RE: Project Number(s) SL23249015 Penalty Amended After Reconsideration Review

Dear Administrator:

On May 31, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 9, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 9, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 9, 2022, found not corrected at the time of the May 31, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00
~~**0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500.00**~~

The details of the violations noted at the time of this follow-up evaluation completed on May 31, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	R 05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL23249015-1 On May 31, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 9, 2022. At the time of the survey, there were 49 residents: 38 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include the Appendix Z 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	{0 680}		

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{0 680}	Continued From page 2 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: The licensee provided their undated disaster plan. The licensee's written emergency disaster plan lacked the following required content: - The EP Programs Patient Population and procedure for the tracking of staff and patients - development of all policy and procedures: -for sheltering in place -for handling medical documents -for handling and use of volunteers - arrangement with other facilities (including sister facilities); - a process for contacting Emergency officials and their information; - a process for alternate means of communication and methods of sharing information; - sharing information on occupancy/needs; and - long term care (LTC) family notifications On May 31, 2022, at 10:12 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated not all corrections had been made as they were still working on the emergency preparedness plan. LALD-A indicated a risk assessment had been completed, but they did not have all the required content for appendix Z. On May 31, 2022, at 1:15 p.m. LALD-A verified missing content of emergency preparedness plan and stated "everything is still a work in progress."	{0 680}		

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{0 680}	Continued From page 3 The licensee's Emergency & Disaster Preparedness policy dated August 1, 2021, indicated the licensee would be prepared to manage emergency and disaster situations. No other information was provided.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	{0 810}		

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{0 810}	Continued From page 4 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No Further Action Required	{0 810}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all 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 the potential to affect a large portion or all the residents).	{0 970}		

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{0 970}	Continued From page 5 The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 20, section 29 of the contract indicated "As an occupant of the facility, resident assumes the risk for resident's own safety, and for the safety of resident's personal property, guests and agents. Resident will indemnify and hold harmless facility, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident or resident's guests of the apartment or any other part of facility, or caused wholly or in part of an act or omission of resident or resident's guest or agents." On May 31, 2022, at 1:15 p.m. licensed assisted living director (LALD)-A verified the licensee's contract included the above content, and stated the same contract was utilized for all residents residing within the facility. LALD-A stated no changes had been made to the contract since the previous survey because the licensee had requested a reconsideration of the correction order. No further information was provided.	{0 970}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:	{02040}		

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{02040}	Continued From page 6 (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No Further Action Required.	{02040}		

Electronically Delivered

April 7, 2022

Administrator
Ridgeway On 23rd
720 23rd Street North
New Ulm, MN 56073

RE: Project Number(s) SL23249015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

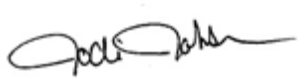
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

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

Sincerely,



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

HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#23249015 On March 7, 2022, through March 9, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 52 residents; 37 receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on March 8, 2022, issued for SL23249015, tag identification 2310. On March 9, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I (level 3, widespread).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 the residents). The findings include: During the entrance conference on March 7, 2022, at 10:50 a.m. LALD-A stated she was the licensee's LALD. On March 7, 2022, at 1:36 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On March 7, 2022, at 1:45 p.m. president (P)-C	0 110		

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0 110	Continued From page 2 verified there was no director of record listed on BELTSS. P-C indicated an application for shared administrator had been completed and submitted, but was not aware of the requirement to identify the director of record. P-C also included both he and clinical nurse specialist (CNS)-B were LALDs, but further verified no one was listed as director of record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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	23249	A. BUILDING: _____ B. WING _____	03/09/2022

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0 470	Continued From page 3 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 interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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: The licensee held an assisted living with dementia care license, and was licensed for a capacity of 88 residents, and had a current census of 52 residents. The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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	0 470		

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0 470	Continued From page 4 on a 24-hour per day basis; and - ensured 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. On March 7, 2022, at 4:00 p.m. licensed assisted living director (LALD)-A indicated the licensee had not developed a staffing plan. The licensee's Staffing, Direct-Care Staffing Plan, & Daily Schedule policy dated August 1, 2021, identified the staffing plan would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and would be adequate to address: a. each resident's needs as identified in the service plan and assisted living contract; b. each resident's acuity level as determined by the most recent assessment or individualized review; c. ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises; d. the staffing plan will indicate if the assisted living has a secured dementia care unit; and e. staff competency and training. The policy further indicated the staffing plan would be evaluated for the appropriate levels of staffing in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 580	Continued From page 5	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, 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: On March 7, 2022, at approximately 10:50 a.m. during the entrance conference licensed assisted	0 580		

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0 580	Continued From page 6 living director (LALD)-A indicated prior to the COVID-19 pandemic, the licensee had quarterly meetings; however, they had not had any since, and was unable to provide any documentation of ongoing quality management activities relevant to the size and services provided. The licensee's Quality Management Plan dated August 1, 2021, noted the LALD would establish a quality management program to develop and maintain the licensee's continuous performance improvement efforts. Documentation of meetings would be retained for two years and made available to the commissioner at the time of survey, investigation, or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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0 640	Continued From page 7 by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. 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: On March 7, 2022, at approximately 12:00 p.m. the facility was observed to be lacking posting of the MAARC hotline in the common areas of the facility. Licensed assisted living director (LALD)-A confirmed this finding and indicated she was not aware it had been missing. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated residents, family and staff would receive education on maltreatment and how to report alleged maltreatment to the facility and to the MAARC. The policy further included: The information will be prominently posted on the board outside in the front vestibule of the facility and will include the phone number for MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 640		

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0 640	Continued From page 8 (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include the Appendix Z required content. This had the potential to affect	0 680		

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0 680	Continued From page 9 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: The licensee provided their undated disaster plan. The licensee's written emergency disaster plan lacked the following required content: - The EP Programs Patient Population and procedure for the tracking of staff and patients - development of all policy and procedures: -for sheltering in place -for handling medical documents -for handling and use of volunteers - arrangement with other facilities (including sister facilities); - a process for contacting Emergency officials and their information; - a process for alternate means of communication and methods of sharing information; - sharing information on occupancy/needs; and - LTC family notifications On March 9, 2022, at 9:45 a.m. licensed assisted living director (LALD)-A confirmed they did not have all the required content for appendix Z. The licensee's Emergency & Disaster Preparedness policy dated August 1, 2021,	0 680		

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0 680	Continued From page 10 indicated the licensee would be prepared to manage emergency and disaster situations. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 11 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 9, 2022, at approximately 10:30 a.m. with licensed assisted living director (LALD)-A, president (P)-C, and maintenance (M)-G on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that the fire safety and evacuation plan did not have employee actions to be taken in the event of a fire or similar emergency. During interview, LALD-A stated that the fire safety and evacuation plan did not have provisions for this requirement.	0 810		

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0 810	Continued From page 12 Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, LALD-A stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, LALD-A stated that the fire safety and evacuation plan did not have provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, LALD-A stated that the licensee provides training to employees on fire safety at initial hire and annually thereafter. A policy was not provided on this. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, LALD-A stated that the licensee had not conducted any evacuation drills for the facility since the law went into effect August 1, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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0 970	Continued From page 13 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all 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 the potential to affect a large portion or all the residents). The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 20, section 29 of the contract indicated "As an occupant of the facility, resident assumes the risk for resident's own safety, and for the safety of resident's personal property, guests and agents. Resident will indemnify and hold harmless facility, its employees, and agents from and against any and all claims, actions, damages, and liability and	0 970		

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0 970	Continued From page 14 expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident or resident's guests of the apartment or any other part of facility, or caused wholly or in part of an act or omission of resident or resident's guest or agents." On March 9, 2022, at 2:30 p.m. president (P)-C verified the licensee's contract included the above content, and stated the same contract was utilized for all residents at the facility. The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 15 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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.	01470		

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01470	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility statutes included all the required content for one of three employees (unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on August 21, 2021, to provide direct care services to residents at the facility. On March 8, 2022, at 11:00 a.m. ULP-D was observed assisting R4 with dressing and toileting. ULP-D's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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	23249	A. BUILDING: _____ B. WING _____	03/09/2022

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01470	Continued From page 17 Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 9, 2022, at approximately 9:30 a.m. licensed assisted living director (LALD)-A confirmed ULP-D's employee record lacked evidence of all the required orientation. The licensee's Orientation-All Staff policy dated August 1, 2021, indicated all newly hired staff would receive orientation and training on topics required for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 18 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment when required for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 began receiving services under the assisted living with dementia care licensure on January 12, 2022, with a diagnoses including Parkinson's disease.	01620		

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01620	Continued From page 19 R1's Service Plan dated February 17, 2022, indicated R1 received services which included medication administration, bathing, meal reminders, laundry, and housekeeping. R1's most recent assessment included a 14-day assessment dated January 12, 2022. R1's record lacked a change of condition assessment following falls and addition of services. R1's Incident Report Notes dated January 24, 2022, at 9:14 a.m. identified R1 had fallen on January 22, 2022, and January 23, 2022. Documentation identified the new environment as a causal factor and the licensee would obtain physical therapy orders for strengthening. Incident Report dated January 25, 2022, at 3:00 a.m. identified R1 fell getting up up from bed to go to the bathroom. No injury was obtained. Incident Report dated January 29, 2022, at 10:30 p.m. identified resident fell in bedroom closet. R1's Notes dated January 31, 2022, at 2:07 p.m. indicated R1 had extensive bruising to right upper extremities following the fall. The note identified R1 had recently started Seroquel (antipsychotic) on January 17, 2022, and had been taking a double dose of what the prescriber had ordered. A call was placed to daughter and message left regarding concern with R1 continuing to manage her own medications. R1's Resident Notes dated February 2, 2022, at 1:48 p.m. indicated staff would continue with plan of nurse setting up the medications and staff administering.	01620		

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01620	Continued From page 20 Incident Report dated February 4, 2022, at 7:45 a.m. identified R1 fell walking from bathroom back to bed and sustained a small skin tear to right hand. A note dated February 4, 2022, at 8:20 a.m. indicated physical therapy would be starting the following week with R1. R1's Incident Report Notes dated February 7, 2022, at 5:30 p.m. identified R1 had fallen in R1's apartment. A follow up noted dated February 8, 2022, at 2:46 p.m. indicated R1 had lost her balance and fell. The note identified Occupational Therapy would be ordered. Resident Notes dated February 10, 2022, at 10:54 a.m. noted R1 had pounded angrily on another resident's door during the night and had been yelling and accusing the resident of sleeping with her husband. 911 was called, and R1 was transported to the emergency room. Resident Notes dated February 11, 2022, at 9:12 a.m. indicated R1 had an appointment on February 14, 2022, with the provider to address hallucinations, paranoia, and behaviors. Resident Notes dated February 11, 2022, at 1:21 p.m. identified R1 had pounded on another resident's apartment door and pushed her way into the apartment yelling and accusing resident of sleeping with her husband. Staff intervened and R1 was again evaluated in the emergency room. Incident Report dated February 14, 2022, at 8:34 a.m. identified R1 fell trying to close her bedroom door. A follow up note on February 14, 2022, at 3:04 p.m. included R1 was encouraged to use her walker when ambulating around apartment.	01620		

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01620	Continued From page 21 Incident Report dated February 16, 2022, at 1:30 p.m. noted R1 lost her balance and fell into her laundry basket. Resident Notes February 18, 2022, at 8:41 a.m. identified licensee staff were coordinating with emergency room, a behavioral unit, and family for a short-term psychiatric stay to help manage behaviors and hallucinations. At 5:31 p.m. R1 returned from emergency room with a new medication order. Incident Report dated February 23, 2022, at 4:00 a.m. identified R1 fell in bathroom witnessed by family member. A follow up note dated February 23, 2022, at 1:47 p.m. included R1 was receiving therapies and fall precautions were reviewed. On March 9, 2022, at 9:50 a.m. clinical nurse specialist (CNS)-B stated R1 should have had a change in condition assessment "with everything going on with her." CNS-B verified a change in condition assessment should have been completed since she had fallen, started therapy, and medication management services had been added. The licensee's Initial and Ongoing Nursing Assessments of Residents dated August 1, 2021, identified the CNS or RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment; b. 14-day assessment completed up to 14 days after start of services; c. Ongoing assessment completed periodically but no less than every 90-days; and d. Change in resident condition.	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 23 Based on interview and record review, the licensee failed to ensure the service plan included all the required content for four of four residents (R1, R2, R3, and R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's Service Plan dated February 17, 2022, indicated R1 received services which included medication administration, bathing, meal reminders, laundry, and housekeeping. R1's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2 R2's Service Plan dated July 28, 2021, indicated R2 received medication administration, blood sugar and insulin monitoring, meal reminders, laundry, and housekeeping.	01650		

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01650	Continued From page 24 R2's Service Plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3's Service Plan dated July 27, 2021, indicated R3 received services which included medication administration, assistance with dressing, feeding, oral hygiene, toileting and bathing. R3's service plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: -the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4 R4's Service Plan dated July 29, 2021, indicated R4 received services which included medication administration, hands-on assistance with transfers and mobility, and assistance with dressing, grooming, toileting, and bathing. R4's service plan lacked the following: - the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 25 - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: -the circumstances in which emergency medical services are not go be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On March 8, 2022, at 2:41 p.m. clinical nurse specialist (CNS)-B verified the content was lacking on the service agreement and stated the same service agreement format was utilized for all residents within the facility. The licensee's Contents of Service Plans policy dated August 1, 2021, noted the service plan would include schedule and methods of monitoring assessments, schedule and methods of monitoring staff providing services, and a contingency plan that included circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040		

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02040	Continued From page 26 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 9, 2022, at approximately 10:30 a.m. with licensed assisted living director (LALD)-A, president (P)-C, and maintenance (M)-G on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical	02040		

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02040	Continued From page 27 environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and	02110		

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02110	Continued From page 28 (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1 R1 started receiving services January 11, 2022. R1's record lacked evidence to have received required policies and procedures for assisted living with dementia care. R2 R2 started receiving services December 10,	02110		

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02110	Continued From page 29 2019, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R2's record lacked evidence to have received required policies and procedures for assisted living with dementia care. R3 R3 started receiving services November 24, 2018, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R3's record lacked evidence to have received the required policies and procedures for assisted living with dementia care. R4 R4 started receiving services April 1, 2015, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care on August 1, 2021. R4's record lacked evidence to have received the required policies and procedures for assisted living with dementia care. On March 9, 2022, at 9:47 a.m. licensed assisted living director (LALD)-A and clinical nurse specialist (CNS)-B acknowledged the licensee's residents and the residents' legal and designated representatives had not receive the required dementia care policies. The licensee lacked a policy or procedure to provide and document receipt of required policies and procedures provided to residents at the time	02110		

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02110	Continued From page 30 of move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02110		
02310 SS=I	144G.91 Subd. 4 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 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 for eight of eight residents (R3, R4, R1, R6, R7, R8, R9, R10) with bedrails. This resulted in an immediate correction order on March 8, 2022, at approximately 4:01 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R3	02310	On March 9, 2022, the immediacy of correction order 2310 was removed, however non-compliance remains at a scope and level of I.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 31 On March 8, 2022, at 12:50 p.m. the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame. R3's diagnosis included dementia. R3's record included a Side-Rail Use Assessment dated May 28, 2021, and indicated R3 had bilateral bedrails used for balance. R3's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements. On March 8, 2022, at approximately 3:25 p.m. clinical nursing supervisor (CNS)-B measured the bedrail with the surveyor present. The bedrail measured 36 inches wide and 18 1/2 inches tall. The gap between the rails was 2 inches, which was in compliance with the Food and Drug Administration (FDA) guidelines for bedrails. CNS-B confirmed R3's bedrail assessment lacked measurements to ensure it was within the FDA recommended dimensional measurements. R4 On March 8, 2022, at 9:00 a.m. the surveyor observed bilateral bedrails near the head of the resident's bed. The bedrails were secured to the bed frame. R4's diagnosis included dementia. R4's record included a Side-Rail Use Assessment dated October 1, 2021, and indicated R4 had bilateral bedrails used for positioning, transfers and support. R4's assessment indicated the licensee reviewed the risks versus benefits of the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 32	02310		

bedrail with resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements.

On March 8, 2022, at approximately 3:27 p.m. CNS-B measured the bedrail with the surveyor present. The bedrail measured 36 inches wide and 18 1/2 inches tall. The gap between the rails was 2 inches, which was in compliance with FDA guidelines for bedrails. CNS-B confirmed R4's bedrail assessment lacked measurements to ensure it was within the FDA recommended dimensional measurements.

R1
On March 7, 2022, at approximately 3:40 p.m. the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame.

R1's diagnosis included Parkinson's disease.

R1's record included a Side-Rail Use Assessment dated January 13, 2022, and indicated R1 had a right-sided bedrail used for positioning, support, and transfers. R1's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements.

On March 8, 2022, at approximately 3:30 p.m. CNS-B measured the bed rail with the surveyor present. The bed rail measured 3 3/4 inches wide by 22 1/2 inches tall. The gap between the rails was 3 3/4 inches, which was in compliance with FDA guidelines for bedrails. CNS-B confirmed R1's bedrail assessment lacked measurements to ensure it was within the FDA recommended dimensional measurements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 33 R6 R6's record included a Side-Rail Use Assessment dated July 2, 2021, and indicated R6 had a left-sided bedrail used for balance and transfers. R6's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements. R7 R7's record included a Side-Rail Use Assessment dated October 8, 2021, and indicated R7 had a right-sided bedrail used for bed mobility, balance and transfers. R7's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements. R8 R8's record included a Side-Rail Use Assessment dated June 1, 2021, and indicated R8 had bilateral bedrails used for bed mobility, balance and transfers. R8's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements. R9 R9's record included a Side-Rail Use Assessment dated July 19, 2021, and indicated R9 had a left-sided bedrail used for safety and/or comfort. R9's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 34 R10 R10's record included a Side-Rail Use Assessment dated July 23, 2021, and indicated R10 had a left-sided bedrail used for positioning and transfers. R10's assessment indicated the licensee reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative, however, the assessment lacked documentation of the bedrail measurements. The licensee's Assessing the Safety of Side Rails policy, undated, noted when a resident had a side rail, the registered nurse (RN) would complete an assessment and evaluate the resident needs and assess to determine if the equipment met the FDA standards for side rails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bedrails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23249	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY ON 23RD	720 23RD STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 35 TIME PERIOD FOR CORRECTION: Immediate On March 9, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/07/22*
Time: 10:15:56
Report: 1020221026

Food and Beverage Establishment Inspection Report

Location:
Ridgeway On 23rd
720 23rd Street North
New Ulm, MN56073
Brown County, 08

Establishment Info:
ID #: 0037635
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073547000
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BOTTLE
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SOUR CREAM - BOTTOM OF PREP COOLER NEXT TO DRY STORAGE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 198 Degrees Fahrenheit - Location: HOT WATER - STEAM WELL
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: RICE - WALK-IN COOLER
Violation Issued: No

Type: Full
Date: *03/07/22*
Time: 10:15:56
Report: 1020221026
Ridgeway On 23rd

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location: CHILI - WALK-IN COOLER
Violation Issued: No

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

GENERAL COMMENTS:

ADDITIONAL CERTIFIED FOOD PROTECTION MANAGER:
PAMELA J. GOSTONEZIK, FM7724, 3/22/22

DISCUSSED CURRENT COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE. DISCUSSED VOMIT CLEAN UP PROCEDURE. A PROCEDURE AND KIT IS AVAILABLE ON-SITE.

DISCUSSED HEATING AND COOLING PROCEDURES.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221026 of 03/07/22.

Certified Food Protection Manager: Jane M. Baker

Certification Number: FM5649 Expires: 12/18/24

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley R
Ashley B

651-201-4500

Report #: 1020221026

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	03/07/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:15:56
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Ridgeway On 23rd	720 23rd Street North	New Ulm, MN	56073	5073547000

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037635		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" 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

		COS	R
Safe Food and Water			
30	IN OUT N/A		
Pasteurized eggs used where required			
31			
Water & ice obtained from an approved source			
32	IN OUT N/A		
Variance obtained for specialized processing methods			
Food Temperature Control			
33			
Proper cooling methods used; adequate equipment for temperature control			
34	IN OUT N/A N/O		
Plant food properly cooked for hot holding			
35	IN OUT N/A N/O		
Approved thawing methods used			
36			
Thermometers provided & accurate			
Food Identification			
37			
Food properly labled; original container			
Prevention of Food Contamination			
38			
Insects, rodents, & animals not present			
39			
Contamination prevented during food prep, storage & display			
40			
Personal cleanliness			
41			
Wiping cloths: properly used & stored			
42			
Washing fruits & vegetables			

		COS	R
Proper Use of Utensils			
43			
In-use utensils: properly stored			
44			
Utensils, equipment & linens: properly stored, dried, & handled			
45			
Single-use/single service articles: properly stored & used			
46			
Gloves used properly			
Utensil Equipment and Vending			
47			
Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48			
Warewashing facilities: installed, maintained, & used; test strips			
49			
Non-food contact surfaces clean			
Physical Facilities			
50			
Hot & cold water available; adequate pressure			
51			
Plumbing installed; proper backflow devices			
52			
Sewage & waste water properly disposed			
53			
Toilet facilities: properly constructed, supplied, & cleaned			
54			
Garbage & refuse properly disposed; facilities maintained			
55			
Physical facilities installed, maintained, & clean			
56			
Adequate ventilation & lighting; designated areas used			
57			
Compliance with MCIAA			
58			
Compliance with licensing & plan review			

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 03/10/22

Inspector (Signature)