DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 5, 2022

Administrator
Cherrywood Of Richmond
140 Barry Avenue Northwest
Richmond, MN 56368

RE: Project Number(s) SL27308015

Dear Administrator:

On September 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 8, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

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

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Electronically Delivered

August 1, 2022

Administrator
Cherrywood Of Richmond
140 Barry Avenue Northwest
Richmond, MN 56368

RE: Project Number SL27308015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 8, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

The total amount you are assessed is $3,500.00. 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

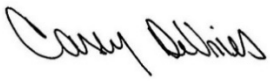
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27308015-0 On July 5, 2022, through July 8, 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 17 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on July 7, 2022, issued for SL27308015-0, tag identification 2310. On July 7, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, widespread scope.	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 interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of 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: Licensed assisted living director (LALD)-B had a license effective through October 31, 2022; however, LALD-B's license lacked the licensee listed as the Director of Record with BELTSS. On July 5, 2022, at approximately 10:35 a.m., LALD-B stated the LALD for this facility was currently on leave of absence, so she was covering. LALD-B stated she would be calling BELTTS to list the licensee as the Director of Record for their license.	0 110		

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0 110	Continued From page 2 The licensee's Assisted Living Director policy, dated August 1, 2021, indicated the licensee was required to have an LALD permitted by BELTTS; however, lacked direction to list as the Director of Record for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 17 residents residing at the facility.	0 480		

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0 480	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a client'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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated July 5, 2022. . TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a	0 485		

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0 485	Continued From page 4 food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure menus were available to the residents and failed to inform residents of menu changes. This had the potential to affect all 17 residents receiving services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: Upon entrance to the facility on July 5, 2022, at approximately 9:15 a.m., the surveyor observed a small blackboard hung on the wall leading into each of the two dining rooms, with the mealtimes posted; however, menus were not posted in the dining or main areas of the facility. On July 8, 2022, at approximately 8:45 a.m., licensed practical nurse (LPN)-H stated the menus were kept in a white binder in a kitchen drawer and were not posted, therefore, residents were not informed of menu changes because they did not really know what the planned menu was for the day.	0 485		

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0 485	Continued From page 5 The licensee's Food Service policy, effective date August 1, 2021, indicated menus will be prepared at least a week in advance and made available to all residents. Also included, residents must be informed in advance of menu changes. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-E, registered nurse (RN)-I) observed to provide personal cares.	0 510		

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0 510	Continued From page 6 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: On July 6, 2022, at approximately 10:07 a.m., with permission from R2, the surveyor observed ULP-E and RN-I assist R2 with morning cares. ULP-E donned gloves and pulled back R2's blankets to unhook the catheter tubing from the urostomy (an opening in the abdominal wall that redirects urine away from bladder). ULP-E carried the urostomy bag containing urine into R2's bathroom and emptied the urine into a urinal to measure R2's urinary output. ULP-E stated, "275," poured the contents into the toilet, placed the urinal under the faucet and filled with a small amount of water, swirled the urinal and dumped the contents into the toilet. ULP-E set the urinal down and, without removing the gloves and performing hand hygiene, ULP-E walked to R2's bedside, picked up socks on a table at the end of the bed, and put R2's socks on. R2 asked the surveyor to leave the room at this time and the surveyor exited the room. On July 6, 2022, at approximately 10:35 a.m., ULP-E verified she did not remove her gloves after emptying the urostomy bag and before continuing to provide personal cares to R2 and confirmed she did not perform hand hygiene. On July 6, 2022, at 10:35 a.m., RN-D stated gloves should have been removed and hand	0 510		

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0 510	Continued From page 7	0 510		

hygiene should have been performed after completing urostomy cares, before continuing to provide other personal cares.

On July 7, 2022, at approximately 7:35 a.m., with R3's permission, the surveyor observed as RN-I prepared to check R3's blood glucose level and to give insulin. RN-I donned gloves, placed a strip in the glucometer, cleaned R3's finger, and used a lancet to poke R3's finger. RN-I placed a drop of blood onto the strip and told R3 the blood glucose level was 158. RN-I removed the strip from the glucometer, threw it into the sharp's container, and without removing her gloves, RN-I reached into R3's medication cupboard, obtained the insulin pen, and began to dial the pen to prime the needle. RN-I stated the pen was almost empty and told R3 she would be right back. Without removing the soiled gloves, RN-I opened R3's room door, touching the door handle, and left the room. RN-I came back to R3's room, soiled gloves still on, and explained she needed to go to get a new insulin pen from the medication refrigerator. RN-I primed the insulin pen, dialed the appropriate amount of insulin, and administered the insulin to R3's abdomen. RN-I placed the insulin pen into the medication cupboard, used a key to lock the cupboard, removed her gloves and performed hand hygiene.

On July 7, 2022, at approximately 8:30 a.m., RN-I stated she realized when she left the room that she still had the gloves on and had not performed hand hygiene; however, RN-I stated she did not remove the gloves at that time and returned to the room with the same gloves to complete the administration of R3's insulin.

On July 7, 2022, at 1:53 p.m., RN-D stated gloves

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0 510	Continued From page 8 need to be removed after potentially coming in contact with blood and hand hygiene must be performed. The licensee's Gloves policy, dated August 1, 2021, directed gloves must be worn whenever there may be direct contact between any employee and contaminated objects. In addition, gloves should be removed, disposed of in proper receptacle and hands should be washed. The licensee's Hand Washing policy, dated August 1, 2021, indicated hand washing would be performed between tasks and procedures to prevent cross-contamination. Also included, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is	0 530		

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0 530	Continued From page 9 not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a staff person to be responsible for providing assistance and responding to written requests that result from meetings and failed to develop a process to consider resident council recommendations and grievances. This had the potential to affect all 17 residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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 July 5, 2022, at approximately 11:20 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated the residents had been "offered" to have a resident council in the past, but no one was interested; however, the licensee had not designated a staff person who was responsible for providing assistance with this and establishing a resident council had not been discussed since the pandemic. The licensee's Resident and Family Councils policy, dated August 1, 2021, indicated the	0 530		

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0 530	Continued From page 10 licensee would provide residents and families the opportunity, space and privacy for meetings, and would "take reasonably achievable steps to make residents and/or family's [sic] aware of upcoming meetings in a timely manner." The policy also indicated the licensee must designate a staff person who was approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. Further, the policy included, "If residents are not willing to do so and the council gives permission, the Assisted Living Director or other assigned staff may lead the meetings." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced	0 540		

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	27308	A. BUILDING: _____ B. WING _____	07/08/2022

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0 540	Continued From page 11 by: Based on interview and record review, the licensee failed to designate a staff person to be responsible for providing assistance and responding to written requests that result from meetings and failed to develop a process to consider family council recommendations and grievances. This had the potential to affect all 17 residents receiving assisted living services, and their families. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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 July 5, 2022, at approximately 11:20 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated the residents' families had been "offered" to have a family council in the past, but no one was interested; however, the licensee had not designated a staff person who was responsible for providing assistance with this and establishing a family council had not been discussed since the pandemic. The licensee's Resident and Family Councils policy, dated August 1, 2021, indicated the licensee would provide residents and families the opportunity, space and privacy for meetings, and would "take reasonably achievable steps to make residents and/or family's [sic] aware of upcoming meetings in a timely manner." The policy also	0 540		

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0 540	Continued From page 12 indicated the licensee must designate a staff person who was approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display the original current license at the main entrance as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 July 5, 2022, at approximately 9:15 a.m., upon entering the facility, the surveyor observed the license was not posted at the facility entrance as required.	0 570		

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0 570	Continued From page 13 On July 5, 2022, at approximately 12:25 p.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the license posted in the housing manager's office, inside the facility approximately five to ten feet, and around the corner, on a wall not visible to the residents or visitors. At this time, LALD-B confirmed the license was not posted at the front entrance as required. The licensee's Assisted Living License and Posting policy, dated August 1, 2022, indicated the issued Assisted Living License would be posted at the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	0 630		

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0 630	Continued From page 14 Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 and R3's records lacked an individual abuse prevention plan which reviewed each resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to those residents and other vulnerable adults. R2 R2's diagnoses included dementia without behavioral disturbance, high blood pressure and bladder cancer. R2's care plan, identified by registered nurse (RN)-D as the service plan, indicated R2 received assistance with managing transportation and appointments, meals, bathing, dressing and undressing, grooming, toileting, transferring, orientation, medication, urostomy care, safety and behavior management.	0 630		

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0 630	Continued From page 15 R2's Vulnerability Assessment, dated January 18, 2022, indicated R2 had dementia and directed staff to orientate as needed, was unable to ambulate and used a wheelchair for all mobility, required staff to keep environment safe/clean, and indicated family managed all finances. The assessment lacked a review of R2's susceptibility to abuse by another individual, risk of abusing other vulnerable adults, and lacked statements of the specific measures to be taken to minimize the risk of abuse. R3 R3's diagnoses included type 2 diabetes, heart failure, high blood pressure, chronic obstructive pulmonary disease and glaucoma. R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration and insulin administration. R3's VA (vulnerability) Assessment, dated July 12, 2021, indicated R3 ambulated with cane or four wheeled walker, wore glasses due to glaucoma, wore bilateral hearing aids, staff kept environment clean and free of clutter, and drinks alcohol daily and is monitored closely for safety. The assessment noted R3 had some identified areas of potential vulnerability, but there were no signs of abuse or neglect; however, the assessment lacked a review of R3's susceptibility to abuse by another individual, risk of abusing other vulnerable adults, and lacked statements of the specific measures to be taken to minimize the risk of abuse. On July 5, 2022, at approximately 3:30 p.m., RN-D verified the template used for the IAPP did not include the required information, therefore, all	0 630		

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0 630	Continued From page 16 residents' IAPP lacked the above content. The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, 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	0 650		

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0 650	Continued From page 17 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for three of four employees (licensed practical nurse (LPN)-F, registered nurse (RN)-D, and unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-F LPN-F started employment on June 9, 2022. LPN-F's record lacked evidence of the following: -evidence of current professional licensure; and	0 650		

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0 650	Continued From page 18 -for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. RN-D RN-D started employment on March 27, 2017. RN-D's employee record lacked the following: -evidence of current professional licensure; and -documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E had a start date of December 15, 2021. ULP-E's employee record lacked the following: -for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On July 7, 2022, at approximately 10:05 a.m., business manager (BM)-G verified the above contents were missing from the employees' records. The licensee's Employee Records policy, dated August 1, 2021, indicated employee records for each person would include: -evidence of current professional licensure, registration or certificate, if required; -records of all training and in-service education required and/or provided including record of competency testing as required; -current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; -documentation of annual performance reviews	0 650		

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0 650	Continued From page 19 that identify areas of improvement needed and training needs; -for individuals providing Assisted Living services, verification that required health screenings for tuberculosis have taken place and the dates of those screenings; -documentation of a completed background study; -evidence that a reference check has been completed; and -verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 20 by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of four employees (licensed assisted living director (LALD)-B) 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's Facility TB (tuberculosis) Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health), dated May 25, 2022, indicated a low risk level. LALD-B was not certain of her exact start date; however, stated the year was 2010. LALD-B stated she was the owner of the facility, and occasionally worked as an unlicensed personnel (ULP). LALD-B's employee record contained evidence of a completed TB history and symptom screening, dated January 3, 2022, and evidence of one negative TST dated November 3, 2010; however,	0 660		

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0 660	Continued From page 21 the record lacked evidence of a second TST, as required. On July 7, 2022, at approximately 10:05 a.m., business manager (BM)-G verified LALD-B's second TST was not documented in her employee record, as required. A policy regarding TB Infection Control was requested but not provided. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated each health care setting in Minnesota should have an up-to-date TB infection control program that included baseline TB screening consisting of three components: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of infection with mycobacterium tuberculosis by administering either a two-step TST or single IGRA (blood test to identify TB). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730		

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0 730	Continued From page 22 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730		

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0 730	Continued From page 23 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R4) 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, 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: R4's diagnoses included vascular dementia, Parkinson's Disease and type 2 diabetes. R4 began receiving services on March 3, 2022, and was discharged on June 24, 2022. R4's service plan, undated, indicated R4 received services including assistance with ambulating, toileting, transfers, medication management, bathing, housekeeping and laundry. R4's record lacked evidence a discharge summary was completed. On July 5, 2022, at approximately 2:18 p.m., registered nurse (RN)-D confirmed a discharge summary that contained the required content had	0 730		

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0 730	Continued From page 24 not been completed for R4, and stated, "I forgot to do one on him." The licensee's Contract Termination policy, dated August 1, 2021, indicated at the time of discharge, Cherrywood would provide the resident, and, with the resident's consent, the resident's representatives and case manager, with a written discharge summary that includes: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the-counter medications, and -a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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
0 810	Continued From page 25 (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 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to	0 810		

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0 810	Continued From page 26 conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On July 6, 2022 between 09:40 a.m. and 12:30 p.m., survey staff toured the facility with the Housing Manager (HM)-C. HM-C failed to provide documents for review. Documents were reviewed by survey staff on July 6, 2022 between 09:40 a.m. and 12:30 p.m., 1. Evacuation map was not available at the end of the hall by exit by room 146 at the time of the survey. 2. The licensee failed to provide employee training logs for fire safety and evacuation. 3. The licensee failed to provide the required employee training frequency. Training documentation was requested by survey staff but were not provided. HM-C verbally confirmed survey staff observations during the facility tour. No additional information was provided	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the	0 930		

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0 930	Continued From page 27 facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3) with records reviewed. This had the potential to affect all 17 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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:	0 930		

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0 930	Continued From page 28 R2 R2's record included a document, identified as R2's service plan, printed July 6, 2022, which indicated R2 received services including assistance with meals, bathing, dressing, grooming, toileting, transferring, safety, medication management, ostomy (drainage tube for bladder) care and behavior monitoring. R2's Resident Agreement signed January 8, 2022, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints. R3 R3's Service Plan, signed July 27, 2017, indicated R3 received assistance with dressing, toileting, ambulation, transfers and medication administration. R3's Resident Agreement signed July 27, 2021, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints. On July 5, 2022, at approximately at 3:20 p.m., registered nurse (RN)-D confirmed the contract provided in the admission packet was the same contract used for all residents. RN-D confirmed the contract lacked the required content as noted above, and further stated contracts would have to be updated for all residents in the facility. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, directed a signed contract would be received by the facility; however, lacked information regarding the	0 930		

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0 930	Continued From page 29 required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four employees (licensed practical nurse (LPN)-F) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01540		

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01540	Continued From page 30	01540		

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:

The licensee had a current assisted living facility with dementia care license.

LPN-F had a hire date of June 9, 2022, to provide direct care services to the licensee's residents.

LPN-F's employee record identified 7.25 hours of training for dementia care completed June 7, 2022, and June 8, 2022.

LPN-F's employee record lacked evidence LPN-F had completed the required eight (8) hours of dementia training on the specific dementia care topics within 80 working hours of LPN-F's hire date, noted as July 2, 2022.

On July 7, 2022, at approximately 9:40 a.m., business manager (BM)-G verified the above hours and stated the licensee failed to reassign a dementia training course that LPN-F failed, therefore, she lacked the required hours.

The licensee's Dementia Training policy, dated August 1, 2022, indicated direct care employees in an assisted living with dementia care licensed facility, would complete eight hours of initial training within 80 hours of the employment start date.

No further information was provided.

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01540	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment using the uniform assessment tool for one of one resident (R2) as required, 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	01610		

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01610	Continued From page 32	01610		

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:

R2 was admitted for services on January 18, 2022.

R2's diagnoses included dementia without behavioral disturbance, high blood pressure and bladder cancer.

R2's care plan, identified by registered nurse (RN)-D as the service plan, indicated R2 received assistance with managing transportation and appointments, meals, bathing, dressing and undressing, grooming, toileting, transferring, orientation, medication, urostomy care, safety and behavior management.

On July 6, 2022, at approximately 10:07 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP-E) and registered nurse (RN)-I assist R2 with morning cares.

R2's record included an initial assessment titled, RN Assessment, dated January 18, 2022. The assessment indicated R2 was admitted due to dementia and requiring 24-hour nursing supervision. The assessment also noted R2 spoke English, had no allergies, current vitals, orientation to the facility, activities of daily living, skin assessment, oral/nutritional assessment, neurological assessment, motor skills, physical assessment, pain assessment, mobility and sensory assessment. The assessment did not include all of the elements on the uniform assessment tool as required and was not

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01610	Continued From page 33 authenticated with the name of the individual who completed it. On July 7, 2022, at 12:26 p.m., RN-D stated assessments were completed in the electronic medical record and, they were not aware that all areas of the uniform assessment tool were not included. RN-D confirmed the initial assessments did not include all required content of the uniform assessment tool and did not indicate who completed the assessment. RN-D also confirmed that the same electronic medical record assessment was used for all residents. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, indicated a registered nurse would complete an initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, be conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	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	01620		

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01620	Continued From page 34 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident 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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services and/or a reassessment not to exceed 90 days as required for three of three residents (R2, R3, R10) 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 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:	01620		

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01620	Continued From page 35 On July 5, 2022, at approximately 11:15 a.m., during the entrance conference, RN-D stated her understanding was assessments should be completed every 90 days and could be a "shorter version", and a comprehensive assessment was required yearly and with a significant change. R2 R2 was admitted for services on January 18, 2022. R2's diagnoses included dementia without behavioral disturbance, high blood pressure and bladder cancer. R2's care plan, identified by RN-D as the service plan, indicated R2 received assistance with managing transportation and appointments, meals, bathing, dressing and undressing, grooming, toileting, transferring, orientation, medication, urostomy care, safety and behavior management. On July 6, 2022, at approximately 10:07 a.m., with permission from R2, the surveyor observed unlicensed personnel (ULP-E) and RN-I assist R2 with morning cares. R2's record included an initial assessment titled, RN Assessment, dated January 18, 2022. R2's record lacked any further assessments, therefore, lacked a reassessment and monitoring no more than 14 calendar days after initiation of services and ongoing resident reassessment and monitoring based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the assessment. R3 R3 was admitted for services on May 25, 2021.	01620		

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01620	Continued From page 36 R3's diagnoses included type 2 diabetes, heart failure, high blood pressure, chronic obstructive pulmonary disease and glaucoma. R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration and insulin administration. On July 7, 2022, at approximately 7:35 a.m., the surveyor observed while RN-I checked R3's blood sugar and administered insulin. R3's record included an initial assessment titled, RN Assessment, dated July 12, 2021. R3's record lacked any further assessments, therefore, lacking ongoing resident reassessment and monitoring based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the assessment. R10 R10 was admitted for services on February 15, 2022. R10 had diagnoses including anemia and Parkinson's Disease. R10's Service Plan, dated February 15, 2022, indicated R10's services included bathing, dressing, grooming, transfer assist, toileting, meals, laundry and housekeeping. R10's record included an initial assessment titled, RN Assessment, dated February 15, 2022. R10's record lacked any further assessments, therefore, lacked a reassessment and monitoring no more than 14 calendar days after initiation of services and ongoing resident reassessment and	01620		

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01620	Continued From page 37 monitoring based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the assessment. On July 7, 2022, at approximately 12:48 p.m., RN-D verified the above assessments were not completed timely per the regulations. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, directed resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Also included, 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. 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:	01650		

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01650	Continued From page 38 (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: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 R2's care plan, identified by registered nurse (RN)-D as the service plan, indicated R2 received assistance with managing transportation and	01650		

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01650	Continued From page 39 appointments, meals, bathing, dressing and undressing, grooming, toileting, transferring, orientation, medication, urostomy care, safety and behavior management. R2's service plan lacked the following required content: -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: (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. R3 R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration, and insulin administration. The service plan identified the licensee as a comprehensive home care provider, therefore, contained information related to the comprehensive licensure regulations, instead of the assisted living with dementia care licensure regulations, and lacked the required content.	01650		

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CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

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01650	Continued From page 40 R3's service plan lacked the following required content: -the schedule and methods of monitoring assessments of the resident; and -the methods of monitoring staff providing services. On July 7, 2022, at approximately 12:37 p.m., RN-D verified R2 and R3's service plans were not the same, and neither included the required information. The licensee's Service Plan policy, dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place that would include the following: -a description of the services that are to be provided based on the most recent assessment and resident preferences; -fees for services to be provided; -the frequency of each service to be provided based on the most recent assessment and resident preferences; -an identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); -schedule and method for the next planned assessment or monitoring; -schedule and method for the next planned monitoring of staff providing services; -a contingency plan that includes: i. Actions Cherrywood will take if scheduled services cannot be provided ii. Information regarding how the resident can contact Cherrywood iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition	01650		

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01650	Continued From page 41 iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700		

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01700	Continued From page 42 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 July 5, 2022, at approximately 11:06 a.m., licensed assisted living director (LALD)-B and RN-D stated the licensee provided medication management services to the licensee's residents. R2 R2's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - indications for medications; - side effects; - contraindications; and	01700		

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01700	Continued From page 43 - allergic or adverse reactions and actions to address these issues. R2 had a contract dated January 18, 2022. R2's care plan, identified by registered nurse (RN)-D as the service plan, indicated R2 received assistance with managing transportation and appointments, meals, bathing, dressing and undressing, grooming, toileting, transferring, orientation, medication, urostomy care, safety and behavior management. R2's prescriber orders, dated January 17, 2022, included one antihypertensive (lowers blood pressure), one medication to treat Alzheimer's disease, two medications for heart health and one antidepressant. R2's Nurses Medication Administration Record, dated June 1, 2022, through June 30, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R2's record included a Senior Living Assessment dated January 18, 2022, which included a medication assessment; however, lacked the above required content. R3 R3's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - must be conducted face to face; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions and actions to	01700		

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01700	Continued From page 44	01700		

address these issues; and
- identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.

R3 had a contract dated July 27, 2021.

R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration and insulin administration.

R3's prescriber orders, dated June 4, 2021, included an inhaler, one medication to treat gout, one medication to treat itching, a medication to treat heart failure, two eye drops and one nasal spray to treat allergies.

R3's Nurses Medication Administration Record, dated June 1, 2022, through June 30, 2022, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.

R3's record included an RN Assessment dated July 12, 2021; however, lacked the above required content.

On July 7, 2022, at approximately 12:40 p.m., RN-D confirmed the assessments lacked the above required content.

The licensee's Medication Management-Assessment, Monitoring & Reassessment policy, dated August 1, 2021,

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01700	Continued From page 45 indicated, prior to providing medication management services, the RN would conduct an assessment to determine what medication services will be provided and how the services would be provided. The assessment must be conducted face-to-face, must include an identification and review of all medications the resident is known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790		

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01790	Continued From page 46	01790		

medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was

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01790	Continued From page 47 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 5, 2022, at approximately 11:06 a.m., licensed assisted living director (LALD)-B and RN-D stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated for unplanned time away when the pharmacy was not able to provide	01790		

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01790	Continued From page 48 the medications, a licensed nurse or properly trained and competency tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days. For unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has developed written procedures for the ULP. On July 7, 2022, at approximately 1:53 p.m., RN-D stated she had trained and delegated ULP to give residents medications for unplanned time away; however, stated she had not developed written procedures for the unlicensed personnel, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to renew prescriptions at least every 12 months for one of two residents (R3) with record reviewed. This practice resulted in a level two violation (a	01830		

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01830	Continued From page 49	01830		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3's record lacked an annual renewal of prescriber orders for medications.

R3's diagnoses included type 2 diabetes, heart failure, high blood pressure, chronic obstructive pulmonary disease and glaucoma.

R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration and insulin administration.

R3's Individualized Medication Management Plan, dated May 24, 2022, indicated R3 received medication administration by facility staff.

On July 7, 2022, at approximately 7:35 a.m., with R3's permission, the surveyor observed as registered nurse (RN)-I checked R3's blood glucose level and gave insulin.

R3's Nurses Medication Administration Record, dated July 1, 2022, through July 6, 2022, included the following medications:
-allopurinol (treats gout) 100 mg (milligrams) by mouth (po) one time daily;
-atorvastatin calcium (treats high cholesterol) 20 mg po daily;
-diphenhydramine hydrochloride (treats itching)

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01830	Continued From page 50 25 mg po one time daily every Tuesday at bedtime; -fluticasone propionate suspension (treats allergies) one spray in both nostrils daily; -glargine (long-acting insulin to treat diabetes) 42 units subcutaneously (under the skin) daily; -latanoprost solution 0.005% (treats glaucoma) one drop in both eyes daily; -magnesium oxide (supplement) 400 mg po one time daily; -melatonin (for sleep) 3 mg po daily; -metolazone (treats high blood pressure and fluid retention) 2.5 mg po daily every Tuesday; -metoprolol succinate extended release (treats high blood pressure) 12.5 mg po daily; -omeprazole (treats heartburn) 20 mg po daily; -tamsulosin hydrochloride (treats prostate) 0.4 mg po daily; -umeclidinium bromide aerosol powder (treats symptoms of chronic obstructive pulmonary disease) one inhalation daily; -vitamin D3 (supplement) 2000 units po daily; -apixaban (prevents blood clots) 2.5 mg po twice daily; -FiberCon (treats constipation) one tab po twice daily; -potassium chloride extended release (supplement) 20 meq (milliequivalents) po twice daily; -torsemide (treats fluid retention) 100 mg po twice daily; -fluorometholone suspension 0.1% (reduce swelling in eyes) instill one drop both eyes three times daily; and -albuterol sulfate (treats shortness of breath) 108-90 base micrograms (mcg) two puffs inhale four times daily. R3's most current prescriber orders, dated June 4, 2021, included all of the above medications;	01830		

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01830	Continued From page 51 however, was 33 days past the annual renewal date requirement. On July 7, 2022, at approximately 1:47 p.m., RN-D confirmed R3's prescriber orders had not been updated at least annually as required. The licensee's Medication & Treatment Orders-Renewal policy, dated August 1, 2021, indicated residents who receive medication management services would have a current physician prescribed medication order on record. The policy further included medication orders must be renewed at least every 12 months, or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	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 refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and/or document medication refrigerator temperatures for two of two medication refrigerators (140 side, 150 side).	01880		

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01880	Continued From page 52 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 5, 2022, at approximately 11:06 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-D stated the licensee provided medication management services to the licensee's residents, including storage of medications. The surveyor requested a history of recorded temperature logs for the licensee's two medication refrigerators, one on the "140 side" and one on the "150 side" of the facility. On July 7, 2022, at approximately 1:47 p.m., RN-D stated she could not locate a temperature log for either medication refrigerator and indicated it was the responsibility of staff working on the overnight shift to monitor and record the temperatures. On July 7, 2022, at apprximately 1:53 p.m., the surveyor observed the medication refrigerators with RN-D. On the "140 side," which contained two unopened insulin pens of glargine insulin and an unopened vial of Tubersol (solution used to test for tuberculosis), the temperature of the medication refrigerator was 35 degrees Fahrenheit (F). On the "150 side" the temperature was 34 degrees F; however, there were no medications in the refrigerator.	01880		

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01880	Continued From page 53 The manufacturer's instructions for glargine dated September 19, 2017, indicated it was recommended that unopened insulin be stored in a refrigerator at approximately 36 to 46 degrees F to maintain potency. Do not use glargine insulin that has been frozen. The manufacturer's instructions for Tubersol, undated, indicated it was recommended to be stored in a refrigerator at 35 to 46 degrees F. The licensee's Medication Storage policy, dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 54 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services plans were revised to reflect the current treatment or therapy service provided for one of two residents (R3) 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: R3 was admitted for services on May 25, 2021. R3's diagnoses included type 2 diabetes, heart failure, high blood pressure, chronic obstructive	01940		

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01940	Continued From page 55 pulmonary disease and glaucoma. R3's physician orders, dated May 25, 2021, included blood glucose checks once daily. R3's Service Plan, dated July 27, 2021, indicated R3 required assistance with bathing, dressing, toileting, medication administration and insulin administration. The service plan did not include the blood glucose checks. On July 5, 2022, at approximately 3:30 p.m., registered nurse (RN)-D verified R3's service plan did not include all of his current services and stated should have included the daily blood glucose checks. On July 7, 2022, at approximately 7:35 a.m., the surveyor observed while RN-I checked R3's blood sugar and administered insulin. The licensee's Service Plan policy dated August 1, 2021, indicated service plans were reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
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	02110		

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02110	Continued From page 56 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 (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, 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 residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia	02110		

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02110	Continued From page 57 care. 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 lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license through July 31, 2022, and was licensed for a bed capacity of 20 residents. On July 5, 2022, at 3:30 p.m., registered nurse (RN)-D confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative. The licensee's Assisted Living with Dementia Care Additional Required Policies policy, dated August 1, 2021, indicated the required written policies and procedures for a facility with an Assisted Living with Dementia Care license, must be provided to residents and the residents' legal and designated representatives at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	02110		

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02110	Continued From page 58 (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and	02170		

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02170	Continued From page 59 (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for three of three residents (R1, R2, R3) who resided in the assisted living with dementia care facility, 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 facility had an assisted living with dementia care license, effective August 1, 2021. R1 R1's diagnoses included Alzheimer's Disease, demoralization (feelings of hopelessness) and apathy (lack of interest). R1's most current RN (registered nurse) Assessment, dated September 21, 2021, indicated R1 ambulated independently, required supervision with eating, dressing and grooming and required bathing assistance. On July 5, 2022, at approximately 12:59 p.m., R1 ambulated independently into the common area	02170		

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02170	Continued From page 60	02170		

and visited with the surveyor. R1 stated she was out for a walk to stretch her legs, and stated, "I'm so bored. There's nothing to do here. I could take a nap, but you can only sleep so much. I'm just not tired anymore." R1 then ambulated down a hallway and the surveyor overheard R1 conversing with staff. R1 stated, "Nothing. I don't have nothing to do. I wish I had something to do." The unidentified staff member replied, "I don't have any laundry for you to fold today," and continued walking away from R1, down the hallway.

R1's record lacked an evaluation for activities that addressed the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

In addition, R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs, as required.

R2
R2's diagnoses included dementia, high blood pressure and bladder cancer.

R2's Service Plan, printed July 6, 2022, indicated R2 required assistance with bathing, dressing, grooming, toileting, transferring, cognition, medications, safety and behaviors. The Service Plan also indicated R2 would be assisted to identify activity preferences, encouraged to participate in activities of interest, and would be

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02170	Continued From page 61 escorted to all activities of interest. On July 5, 2022, through July 8, 2022, the surveyor observed R2 several times throughout the survey, sitting in his room, in a transport-type wheelchair, with his television on. At times, R2 was actively watching television and other times, his eyes were closed. R2's record lacked an evaluation for activities that addressed the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs. R3 R3's diagnoses included type 2 diabetes, heart failure, chronic obstructive pulmonary disease and high blood pressure. R3's most current RN Assessment, dated July 12, 2021, indicated R3 required assistance with dressing, bathing, toileting and personal hygiene. On July 5, 2022, through July 8, 2022, the surveyor observed R3 several times throughout the survey, in his room with visitors, self-propelling his wheelchair to meals and to the common area for social time with other residents in the afternoon.	02170		

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02170	Continued From page 62 R3's record lacked an evaluation for activities that addressed the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs. Review of the licensee's Activity Calendar, undated, included Sunday through Saturday, intended to be used every week. Each day, the morning activity included, "AM - Exercise." The afternoon activity on Sunday was identified as movie and popcorn, Monday was identified as arts and crafts with snack, Tuesday was identified as bingo and snack, Wednesday was identified as "Wild Wednesday" with beer/wine with snack and activity of choice, Thursday was identified as ice cream social and activity of choice, Friday was identified as music and snack, and Saturday was identified as bingo and snack. On July 5, 2022, through July 8, 2022, throughout the survey, the surveyor did not observe residents engaging in exercises on either wing of the facility; however, some residents did gather in the common area in the afternoon for a snack and bingo on Tuesday, a snack on Wednesday, and ice cream and a movie on Thursday. On July 7, 2022, at approximately 11:13 a.m., unlicensed personnel (ULP)-E stated residents didn't really want to do exercises in the morning	02170		

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02170	Continued From page 63 after breakfast, and that they preferred to go back to their rooms. On July 7, 2022, at approximately 12:47 p.m., registered nurse (RN)-D stated there wasn't anyone that was designated to do activities with the residents; however, the floor staff were responsible for engaging in activities with the residents. RN-D stated, "Nobody [residents] really wants to do anything." When the surveyor asked about the exercises scheduled in the mornings, RN-D stated, "Exercises don't really get done. Residents usually just go back to their rooms after breakfast." The licensee's ALFDC Life Enrichment Programs, Activities & Outdoor Space policy, dated August 1, 2021, indicated morning exercises and afternoon activities would strive to be as inclusive as possible and staff would strive to provide modifications to activities to allow for resident participation. Also included, each resident must be evaluated for activities according to the licensing rules of the facility and must include past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptions necessary for the resident to participate, and identification of activities for behavioral interventions. Further, an individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs with a selection of daily structured and non-structured activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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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 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 for eight of eight residents (R5, R10, R9, R8, R2, R6, R7, R3) with siderails. 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). This resulted in an immediate correction order being issued on July 7, 2022. The findings include: R5 On July 6, 2022, at approximately 1:08 p.m., the surveyor observed registered nurse (RN)-D measure R5's left upper siderail, which was affixed to the bed. The siderail was metal, had six vertical bars in the middle with five openings, and five horizontal bars with four openings, on each side. The openings between the bars for zone 1	02310	On July 7, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, widespread scope.	

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varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 4 1/2 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 2 3/4 inches.

R5 had diagnoses including dementia, depressive disorder, epilepsy, and osteoarthritis.

R5's Service Plan, dated July 27, 2021, indicated R5's services included bathing, dressing, grooming, ambulation and transfer assist, toileting, meals, laundry and housekeeping.

R5's medical record included education of the risks and benefits associated with the use of siderails, signed by R5's representative on March 4, 2019.

R5's medical record included Side Rail Assessment, dated February 19, 2021, indicated R5's siderails promoted independence with bed mobility, repositioning, and to sit up in bed, and indicated the risks versus benefits had been reviewed with R5's responsible party and that they chose to continue the use of siderails. Also included, the assessment indicated there were no safety risks and the measurements met the recommendations of the Food and Drug Administration (FDA); however, lacked documentation of a siderail assessment to include measurements.

R10
On July 6, 2022, at approximately 1:12 p.m., the surveyor observed RN-D measure R10's left upper siderail, which was affixed to the bed. The

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02310	Continued From page 66 siderail was metal, had six vertical bars in the middle with five openings, and four horizontal bars with three openings, on each side. The openings between the bars for zone 1 varied, with the largest opening measuring 3 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 1/2 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 1 1/2 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3 3/4 inches. R10 had diagnoses including anemia and Parkinson's Disease. R10's Service Plan, dated February 15, 2022, indicated R10's services included bathing, dressing, grooming, transfer assist, toileting, meals, laundry and housekeeping. R10's medical record lacked education of the risks and benefits associated with the use of siderails. R10's medical record lacked documentation of a siderail assessment to include measurements. R9 On July 6, 2022, at approximately 1:15 p.m., the surveyor observed RN-D measure R9's right upper siderail, which was affixed to the bed. The siderail was metal, had six vertical bars in the middle with five openings, and five horizontal bars with four openings, on each side. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 inches. The measurements between the top of the rail to the	02310		

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head of bed for zone 6, measured 3 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 2 1/4 inches.

R9 had diagnoses including atrial fibrillation (irregular, fast heartbeat), high blood pressure, edema, and has a pacemaker.

R9's service plan, printed July 6, 2022, indicated R9's services included dressing assistance, grooming, ambulation supervision, toileting, meals, laundry and housekeeping.

R9's medical record included education of the risks and benefits associated with the use of siderails, signed by R9 on August 21, 2019.

R9's medical record included Side Rail Assessment, dated May 5, 2022, indicated R9's siderail was used for independence with bed mobility, and indicated the risks versus benefits had been reviewed with R9's responsible party and that they chose to continue the use of siderails. Also included, the assessment indicated there were no safety risks and the measurements met the recommendations of the FDA; however, lacked documentation of a siderail assessment to include measurements.

R8
On July 6, 2022, at approximately 1:18 p.m., the surveyor observed RN-D measure R8's bilateral upper siderails, which were affixed to the bariatric bed. The siderails were metal, had 7 vertical bars with six openings. The openings between the bars for zone 1 varied, with the largest opening measuring 4 1/8 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 1/2 inches. The measurements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 68 between the top of the rail to the head of bed for zone 6, measured 2 3/4 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 1 inch. R8 had diagnoses including hemiplegia and hemiparesis (weakness and/or paralysis) affecting left non-dominant side, morbid obesity, osteoarthritis, and depression. R8's service plan, dated July 28, 2021, indicated R8's services included bathing, dressing, grooming, transfers, toileting, medication administration, meals, laundry and housekeeping. R8's medical record included education of the risks and benefits associated with the use of siderails, signed by R8's representative on December 20, 2019. R8's medical record included Side Rail Assessment, dated May 18, 2021, indicated R8's siderail was used for independence with bed mobility and repositioning, and indicated the risks versus benefits had been reviewed with R8's responsible party and that they chose to continue the use of siderails. Also included, the assessment indicated there were no safety risks and the measurements met the recommendations of the FDA; however, lacked documentation of a siderail assessment to include measurements. R2 On July 6, 2022, at approximately 1:23 p.m., the surveyor observed RN-D measure R2's left upper siderail, which was affixed to the bed. The siderail was metal, had six vertical bars in the middle with five openings, and five horizontal bars with four openings, on each side. The openings between	02310		

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	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 69	02310		

the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 1/2 inch, and the measurements between the headboard and the end of the mattress for zone 7, measured 0 inches.

R2 had diagnoses including dementia, high blood pressure, and bladder cancer.

R2's Service Plan, printed July 6, 2022, indicated R2's services included bathing, dressing, grooming, transfer assist, toileting, meals, urostomy (for bladder) care, laundry and housekeeping.

R2's medical record lacked education of the risks and benefits associated with the use of siderails.

R2's medical record lacked documentation of a siderail assessment to include measurements.

R6
On July 6, 2022, at approximately 1:28 p.m., the surveyor observed RN-D measure R6's bilateral upper siderails, which were affixed to the bed. R6 stated she used the siderails to roll from side to side and to reposition. The siderails were metal, had six vertical bars in the middle with five openings, and five horizontal bars with four openings, on each side. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 1/4 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 0 inches on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 70 left, and less than 2 inches on the right, and the measurements between the headboard and the end of the mattress for zone 7, measured 2.5 inches. R6 had diagnoses including chronic kidney disease, heart failure, vitamin D deficiency, major depressive disorder, and chronic pain. R6's Service Plan, dated July 16, 2021, indicated R6's services included bathing, dressing, grooming, transfer and ambulation assist, toileting, medication administration, laundry and housekeeping. R6's medical record lacked education of the risks and benefits associated with the use of siderails. R6's medical record lacked documentation of a siderail assessment to include measurements. R7 On July 6, 2022, at approximately 1:38 p.m., the surveyor observed RN-D measure R7's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had 10 vertical bars with 9 openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 1/2 inches. The measurements between the top of the rail to the head of bed for zone 6, measured 1 1/2 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 4 inches. R7 had diagnoses including cerebral palsy, muscle weakness, moderate protein-calorie malnutrition, and weakness.	02310		

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	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 71 R7's Service Plan, dated July 16, 2021, indicated R7's services included bathing, dressing, grooming, transfers, toileting, medication administration, meals, laundry and housekeeping. R7's medical record included education of the risks and benefits associated with the use of siderails, signed by R7's representative on April 17, 2019. R7's medical record included Side Rail Assessment, dated February 23, 2021, indicated R7's siderail was used "to help staff with bed mobility and repositioning," and indicated the risks versus benefits had been reviewed with R8's responsible party and that they chose to continue the use of siderails. Also included, the assessment indicated there were no safety risks and the measurements met the recommendations of the FDA; however, lacked documentation of a siderail assessment to include measurements. R3 On July 6, 2022, at approximately 4:36 p.m., RN-D measured R3's left upper siderail, which was affixed to the bed, and reported the measurements to the surveyor. The siderail was metal, had 10 vertical bars, with 9 openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 inch. The measurements between the top of the rail to the head of bed for zone 6, measured 3 1/2 inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 0 inches.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 72 R3 had diagnoses including type 2 diabetes, heart failure, chronic gout, glaucoma, and lower urinary tract symptoms. R3's Service Plan, dated July 27, 2021, indicated R3's services included bathing, dressing, grooming, toileting, laundry and housekeeping. R3's medical record lacked education of the risks and benefits associated with the use of siderails. R3's medical record lacked documentation of a siderail assessment to include measurements. On July 6, 2022, at approximately 4:38 p.m., RN-D verified some residents did not have a siderail assessment completed and stated the licensee recently implemented a new siderail assessment; however, neither assessment included measurements. RN-D stated she did not allow any siderails or devices that are placed on the bed unless it was a hospital type bed, with appropriate FDA certified siderails affixed to the bed. RN-D stated she discussed the risk versus benefits of using siderails with residents and their representatives; however, verified she could not find evidence of this for R2, R6, R3, and R10. The licensee's Side Rails policy, dated August 1, 2021, indicated the RN must conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. If the siderail was acting as a restraint, the policy directs that action should be taken. The policy also directed that the resident and the resident's representative, shall be informed of the risks and benefits regarding the use of siderails, and documentation of the education provided would be in the resident record. Further, the licensee's staff would determine if the siderail	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27308	A. BUILDING: _____ B. WING _____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF RICHMOND	140 BARRY AVENUE NW RICHMOND, MN 56368

(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 73 was considered to be safe, meeting all of the following requirements: -siderail is used consistent with manufacturer's directions; -siderails are installed securely and maintained in good operating condition; and -siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment, and siderail zones 1, 2, and 3 must not exceed 4.75 inches. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails 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. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/05/22*
Time: 10:40:11
Report: 7930221099

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Of Richmond
140 Barry Avenue Nw
Richmond, MN56368
Stearns County, 73

Establishment Info:
ID #: 0038657
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202577445
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

LUNCH MEATS IN BOTH KITCHEN REFRIGERATORS WERE OPENED AND NOT DATED. DATE LUNCH MEAT PACKAGES ONCE OPENED TO ENSURE THEY ARE USED WITHIN 7 DAYS.

Comply By: 07/05/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

KITCHEN 2 (FARTHEST FROM MAIN ENTRANCE) DID NOT HAVE A THERMOMETER WITH A THIN TAPERED END. PROVIDE A THIN TIPPED THERMOMETER WITH A TAPERED END.

Comply By: 07/08/22

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

AT TIME OF INSPECTION THERE WERE NOT ANY PAPER TOWELS AT THE HANDWASHING SINK IN KITCHEN 1 (CLOSEST TO THE MAIN ENTRANCE).

Comply By: 07/05/22

2-100 Supervision

2-102.12AMN

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

MICHAEL FENNELL NEEDS TO SIGN UP FOR A CLASS. ONCE THE CLASS IS TAKEN AND PASSED, SEND TEST RESULTS, $35 FEE AND APPLICATION TO GET THE STATE CERTIFICATE. APPLICATION EMAILED WITH REPORT.

Comply By: 08/19/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

PROVIDE THERMOMETERS IN ALL REFRIGERATORS IN BOTH KITCHENS AND DINING ROOMS. AT TIME OF INSPECTION ONLY ONE REFRIGERATOR HAD A THERMOMETER INSIDE OF IT. ALL OTHER UNITS HAD A THERMOMETER IN THE FREEZER.

Comply By: 07/08/22

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

OBSERVED PRESET SILVERWARE SITTING ON TOP OF NAPKINS ON THE TABLE IN EACH DINING ROOM. COVER OR WRAP LIKE STATED ABOVE.

Comply By: 07/05/22

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: FISH--KITCHEN 2
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: MILK--UPRIGHT IN KITCHEN 1 DINING ROOM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MIXED GREENS--UPRIGHT IN KITCHEN 1
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: MILK--UPRIGHT IN KITCHEN 2 DINING ROOM
Violation Issued: No

Type: Full
Date: *07/05/22*
Time: 10:40:11
Report: 7930221099
Cherrywood Of Richmond

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MIXED GREENS--UPRIGHT IN KITCHEN 2
Violation Issued: No

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

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 7930221099 of 07/05/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us

Report #: 7930221099

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	3	Date	07/05/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:40:11
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Cherrywood Of Richmond	140 Barry Avenue Nw	Richmond, MN	56368	3202577445

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038657		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	X		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	X	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) **Date:** 07/06/22

Inspector (Signature) Tina Remmle