Electronically Delivered

April 2, 2025

Licensee
Potter Ridge
1971 Neal Street
Red Wing, MN 55066

RE: Project Number(s) SL30489016

Dear Licensee:

On March 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 4, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: Jodi Johnson Fax: 1-866-890-9290

HHH

Electronically Delivered

February 13, 2025

Licensee
Potter Ridge
1971 Neal Street
Red Wing, MN 55066

RE: Project Number(s) SL30489016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30489	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTTER RIDGE	1971 NEAL STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30489016-0 On December 2, 2024, through December 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 53 residents; 50 receiving services under the Assisted Living Facility license. 2310: An immediate order was issued on December 4, 2024, at a level 3/Widespread G) The licensee took action on December 4, 2024; however, the scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 2, 2024, for the specific Minnesota Food code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 550	Continued From page 3	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 550		

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0 550	Continued From page 4 The findings include: On December 2, 2024, at 9:38 a.m. during the facility tour with executive director (ED)-A, the surveyor observed the licensee's grievance procedure posted in the hallway of the lobby. Though the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and the person responsible for handling resident grievances, the posting lacked information regarding the Minnesota Adult Abuse Reporting Center (MAARC). On December 2, 2024, at 9:52 a.m., ED-A reviewed the posted grievance procedure and stated it did not include information regarding MAARC. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 5 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness plan was reviewed and lacked the following: -arrangement with other faculties (including sister facilities); -conduct exercises to test EP at least twice per	0 680		

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0 680	Continued From page 6 year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On December 4, 2024, at 2:52 p.m., executive director (ED)-A stated they had conducted the required exercises to test EP but did not have the documentation for them. ED-A further stated they could not locate the documents for the facilities they have arrangements with. The licensee's Emergency Preparedness Manual policy, undated, indicated each community would have an Emergency Preparedness Manual that was available to staff at all times. The manual would contain a plan for evacuation, elements of sheltering in place, temporary relocation sites, and details of staff assignments in the event of a disaster or an emergency. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 7 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code and MN Rule 7511 and failed to ensure provided fire safety equipment was maintained in proper working order. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 8 Findings include: On December 2, 2024, from approximately 11:55 a.m. to 2:30 p.m., the surveyor toured the facility with maintenance director (MD)-E. During the tour, the surveyor observed the following: Emergency lighting in chapel room, in hallway near room 006, in South stairwell on several floors, in north stairwell on several floors, in hallway near room 204, in hallway near room 212, in hallway near second floor laundry room, in hallway near room 303, in movie theater room, and in hallway near room 304 did not function properly when tested. Emergency lighting should be maintained to provide illumination when tested to simulate power outage. An illuminated emergency exit sign in the second floor hallway near the laundry room did not function properly when tested. Emergency exit sign should be properly maintained to provide illumination when tested to simulate power outage. A provided smoke alarm unit in resident sleeping room 006 appeared to be of an older model and dated. Upon request MD-E detached alarm and surveyor observed that the alarm was dated 2005 and was past the approved device lifespan. Smoke alarms must not exceed 10 years in age and must be replaced and maintained in proper working order. Provided fire doors leading to the billiards room were propped open and were not maintained free of obstruction. These deficient conditions were visually verified	0 780		

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0 780	Continued From page 9 by MD-E accompanying on the tour and MD-E stated he understood requirements. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 10 On December 2, 2024, from approximately 11:55 a.m. to 2:30 p.m., the surveyor toured the facility with maintenance director (MD)-E. During the tour, the surveyor observed the following: Dryer ventilation was loose from dryer unit which contributed to buildup of lint in laundry room on floor one. Dryer ventilation should be properly maintained to direct exhaust and products away from laundry room, and accumulated lint buildup should be removed. The impropely atached dryer ventilation may lead to a buildup of lint, which may pose a fire hazard if not abated. An outlet cover plate was missing from resident storage room outlet. Escutcheons were missing around three sprinkler heads in hallway near room 313. These deficient conditions were visually verified by MD-E accompanying on the tour and MD-E stated he understood requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 11 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill 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 the fire safety and evacuation plan (FSEP) with required content and failed to include documentation of required room locations, training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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	30489	A. BUILDING: _____ B. WING _____	12/04/2024

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0 810	Continued From page 12 or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, maintenance director (MD)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP binder did not include any floor plans or information on location and number of resident rooms. Floor plans are provided in the facility in elevator lobbies but were not included in FSEP documents. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. MD-E failed to provide documentation of staff trainings on the fire safety and evacuation plan and stated that staff trainings on FSEP documents occurred "once a year." The FSEP failed to identify procedures for resident movement or evacuation during a fire including unique resident needs for evacuation. FSEP documentation of fire drills showed that facility fire drills were not conducted twice per year per shift as required. Fire drill records indicated that fire drills were not conducted during overnight working shifts. During an interview on December 2, 2024, surveyor explained the requirements for frequency of drills, employee trainings and FSEP	0 810		

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0 810	Continued From page 13 documents. MD-E stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	01060		

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01060	Continued From page 14 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R3 was admitted on March 4, 2024, with diagnoses that included diabetes. R3's service plan dated October 8, 2024, indicated R3 received assistance with dressing, shower assistance, hygiene assistance, blood glucose checks, INR monitoring, and medication	01060		

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01060	Continued From page 15 administration. R3's progress note dated April 29, 2024, indicated R3 was admitted to the hospital and when ready to discharge from the hospital, R3 would transfer to a skilled nursing facility for short term rehabilitation. R3 returned to the licensee on May 23, 2024 (24 days later). R3's progress notes dated July 27, 2024, indicated R3 was sent to the emergency room via ambulance and was admitted to the hospital. R3 returned to the licensee on August 2, 2024 (six days later). R3's progress notes dated August 22, 2024, indicated R3 was sent to the emergency room and was admitted to the hospital. R3 returned to the licensee on August 27, 2024 (five days later). R3's After Visit Summary Dated November 4, 2024, indicated the resident was hospitalized from October 23, 2024, to November 4, 2024 (12 days). R3's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 16 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On December 4, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated R3's record lacked evidence a written notice related to R3's emergency relocations had been completed and provided, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. CNS-B further stated she was not aware of this requirement. The licensee's Termination of Residency-Emergency Relocation policy, undated, indicated: 1. When the community believes, and enacts emergency relocation of a resident, the community must provide written notice to the residents, their legal representatives and their designated representatives as soon as possible following the relocation. A copy of the written notice must also be provided to the resident's case manager if the resident is receiving assistance through waiver services. 2. A copy of the notice of emergency relocation will be provided to the Office of Ombudsman for Long-Term Care within 24 hours if the resident has relocated and not returned to the community within four days. No further information was provided.	01060		

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01060	Continued From page 17 TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a),	01470		

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01470	Continued From page 18 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01470		

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01470	Continued From page 19 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on November 6, 2023, to provide direct care and services to the facility's residents. On December 3, 2024, at 10:59 a.m., the surveyor observed ULP-D apply compression stockings and lymphedema wraps to R2's lower extremities. ULP-D's employee record did not include the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services. On December 4, 2024, at 11:38 a.m., corporate clinical nurse supervisor (CCNS)-G stated ULP-C's employee record lacked evidence of the required orientation as listed above. The licensee's All Staff Orientation policy, undated, indicated all assisted living employees would complete an orientation to assisted living facility licensing requirements and regulations	01470		

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01470	Continued From page 20 before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and	01500		

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01500	Continued From page 21 procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01500		

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01500	Continued From page 22 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on July 5, 2021, to provide direct care and services to the facility's residents. On December 2, 2024, at 11:25 a.m., the surveyor observed ULP-C administer medications to R3. ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - reporting of maltreatment of vulnerable adults under section 626.557; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 4, 2024, at 11:31 a.m., corporate clinical nurse supervisor (CCNS)-G stated ULP-C's record lacked the above training as required. The licensee's Annual In-Service Training policy, undated, indicated the annual training for all staff performing direct home care services would include: a. Training on reporting of maltreatment of maltreatment of vulnerable adults under section 626.557. d. The principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 23 support services provided by the staff person. f. Review of agency's policies and procedures related to the provision of services, and how to implement those policy and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident 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	01620		

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01620	Continued From page 24 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments not to exceed 90 days for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. R2's service plan dated June 6, 2024, indicated R2 received assistance with dressing, skin care, hygiene assistance, shower assistance, toileting, ace wraps, brace, compression stockings, exercises, oxygen management, toileting, transfer assistance, escorts, INR monitoring (blood test that measures how long it takes for your blood to clot), and medication administration. R2's ongoing nursing assessments dated February 23, 2024, May 24, 2024, June 5, 2024, August 23, 2024, and September 6, 2024, were reviewed by the surveyor. The May 24, 2024, assessment was completed 91 days after the date of the previous assessment, thus exceeding 90 calendar days.	01620		

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01620	Continued From page 25 On December 4, 2024, at 11:35 a.m., clinical nurse supervisor (CNS)-B stated R2's May 24, 2024, assessment exceeded 90 calendars from the previous assessment. The licensee's Monitoring of Residents and their Services policy, undated, indicated the RN would monitor and reassess the resident in the resident's home no more than 14 days after initiation of Comprehensive home care services by our agency, and thereafter the monitoring and reassessment visits would not exceed 90 days from the date of the last visit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 26 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of three residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. On December 3, 2024, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D disconnect R2's BIPAP (noninvasive breathing device that helps people with breathing difficulties) machine and apply oxygen per nasal cannula. R2's service plan dated June 6, 2024, indicated R2 received assistance with dressing, skin care,	01640		

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01640	Continued From page 27 hygiene assistance, shower assistance, toileting, ace wraps, brace, compression stockings, exercises, oxygen management, toileting, transfer assistance, escorts, INR monitoring (blood test that measures how long it takes for your blood to clot), and medication administration. The service plan did not include medication set up or BIPAP services. R3 R3 was admitted on March 4, 2024, with diagnoses that included diabetes. On December 2, 2024, at 11:25 a.m., the surveyor observed ULP-C administer medications to R3. R3's service plan dated October 8, 2024, indicated R3 received assistance with dressing, shower assistance, hygiene assistance, blood glucose checks, INR monitoring, and medication administration. The service plan did not include medication set up services. R3's signed prescriber orders dated November 21, 2024, included: -warfarin 4 mg by mouth daily On December 4, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated R2 and R3's service plans did not reflect all services provided by the licensee as listed above. At 11:57 a.m., CNS-B stated she set up medications for several residents including R3, but did not document the set up. The licensee's Monitoring and Residents and their Services policy, undated, indicated if changes were needed in the resident's service plan, the RN would discuss the changes with the	01640		

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01640	Continued From page 28 resident and/or the resident's representative and would revise the service plan. The RN would sign the revised service plan and would request that he resident and/or the resident's representative also signed the revised service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for one of three residents (R2) for medication administration delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 29 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: R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. On December 3, 2024, at 10:59 a.m., the surveyor observed ULP-D apply compression stockings and lymphedema wraps to R2's lower extremities. R2's service plan dated June 6, 2024, indicated R2 received assistance with medication administration. R2's record lacked current prescriber orders for the following PRN medications: -oxycodone 5 milligrams (mg) (used for pain) -furosemide 20 mg (used to diurese fluid) -albuterol 0.083% (used to open the airways) -Proair Respiclick 90 micrograms (mcg) (used to open the airways) -Ventolin HFA 90 mcg (used to open the airways) -ipratropium/albuterol 0.5-3 mg/3 milliliter (ml) (used to open the airways) OXYCODONE: R2's Medication Administration Record (MAR) dated December 2024, included the following medication: -oxycodone 5 mg; take one half tablet (2.5 mg) or two half tablets (=5 mg) depending on pain level	01750		

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01750	Continued From page 30 every 4 hours as needed The licensee failed to define the pain level required regarding when one half tablet (2.5 mg) or two half tablets (5 mg) tablets of oxycodone would be given. FUROSEMIDE: R2's MAR dated December 2024, include the following medication: -furosemide 20 mg; take one tablet by mouth daily as needed for shortness of breath/leg swelling R2's furosemide order did not define how much leg swelling had to be present to administer the PRN dose of furosemide. PRN INHALERS/NEBULIZERS: R2's MAR dated December 2024, included the following medications: -albuterol 0.083%; inhale one vial orally via nebulizer every six hours as needed for wheezing or shortness of breath -Proair Respiclick 90 mcg; inhale two puffs by mouth every four hours as needed for wheezing -Ventolin HFA 90 mcg; inhale two puffs by mouth every four hours as needed for shortness of breath or wheezing -ipratropium/albuterol 0.5-3 mg/3 ml inhalation; inhale one vial via nebulizer four times daily as needed for wheezing or shortness of breath The licensee failed to provide instruction for the ULP to understand which PRN medication for shortness of breath and wheezing should be used in which order. On December 4, 2024, at 11:55 a.m., clinical nurse supervisor (CNS)-B stated there were not	01750		

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01750	Continued From page 31 written instructions regarding which PRN medications for shortness of breath or wheezing should be given, and in which order for R2. CNS-B further stated R2's PRN oxycodone order did not define the pain level for when to give one half tablet versus two half tablets. CNS-B further stated R2's furosemide order did not define how much swelling in R2's legs was required to be present to administer the PRN dose. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated if a prescription was incomplete or a prescription for a PRN medication or medication with a variable dosage did not include clear parameters for administration, the RN would notify the prescriber and obtain the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for two of two residents (R2	01770		

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01770	Continued From page 32 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on December 2, 2024, at approximately 9:15 a.m., executive director (ED)-A stated the licensee provided medication management services to their residents, including medication set up. R2 R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. R2's service plan dated June 6, 2024, indicated R2 received assistance with medication administration. The service plan did not include medication set up services. R2's signed prescriber orders dated November 25, 2024, included: -warfarin 3 milligrams (mg) by mouth on Monday. -warfarin 6 mg by mouth on Tuesday, Wednesday, Thursday, Friday, Saturday. -warfarin 5 mg by mouth on Sunday. R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be	01770		

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01770	Continued From page 33 administered, and route of administration. R3 R3 was admitted on March 4, 2024, with diagnoses that included diabetes. On December 2, 2024, at 11:25 a.m., the surveyor observed ULP-C administer medications to R3. R3's service plan dated October 8, 2024, indicated R3 received assistance with medication administration. The service plan did not include medication set up services. R3's signed prescriber orders dated November 21, 2024, included: -warfarin 4 mg by mouth daily On December 4, 2024, at 11:57 a.m., clinical nurse supervisor (CNS)-B stated she set up medications for several residents including R2 and R3 but did not document the medication set up. CNS-B further stated she was unaware of the required documentation for medication set up. The licensee's Content of the Client's Medication Record policy, undated, indicated the client's record would contain documentation of any medication set up by the nurse. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy	01790		

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01790	Continued From page 34 is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (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	01790		

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01790	Continued From page 35 medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for one of two unlicensed personnel (ULP-D) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01790		

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01790	Continued From page 36 ULP-D was hired on November 6, 2023, to provide direct care and services to the facility's residents. On December 4, 2024, at 11:31 a.m., clinical nurse supervisor (CNS)-B stated ULP-D was trained, and competency tested on providing medications to residents for unplanned time away; however, ULP-D's employee record lacked documentation of the training or competencies. The licensee's Medications When a Resident is Away from the Community policy, undated, indicated the RN trained and competency tested the unlicensed staff on procedures to follow when giving medications to residents who would be away from home when medications were scheduled. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of three residents (R1).	01820		

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01820	Continued From page 37 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on September 6, 2024, with diagnoses that included muscle weakness and osteoarthritis. On December 3, 2024, at 9:27 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's signed prescriber orders dated October 1, 2024, included: -acetaminophen 500 milligrams (mg); take 1,000 mg by mouth three times a day (pain reliever) -atorvastatin 80 mg; take one tablet by mouth at bedtime (lower cholesterol) -brimonidine 0.2% ophthalmic solution; administer one drop into the right eye two times a day (for glaucoma) -cetirizine 10 mg; take one tablet by mouth daily (for allergies) -clopidogrel 75 mg; take one tablet by mouth daily (blood thinner) -diclofenac sodium 1% gel; apply four grams (g) four times a day to painful joints and back (pain reliever) -ferrous sulfate 325 mg; take one tablet by mouth every other day (iron supplement) -latanoprost 0005%; instill one drop into left eye at bedtime (for glaucoma)	01820		

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01820	Continued From page 38 -magnesium glycinate 100 mg; take 500 mg by mouth two times a day (supplement) -megestrol 40 mg/milliliter (ml) solution; take 5 ml (200 mg) total by mouth two times a day (hormone supplement) -metoprolol tartrate 50 mg; take one tablet by mouth twice a day (heart health) -multivitamin-iron-FA-CA-minerals 400 micrograms (mcg); take one tablet by mouth daily (vitamin supplement) -nystatin 1000,000 unit/g cream; apply topically two times a day to groin (anti-fungal) -pantoprazole 40 mg; take one tablet by mouth at bedtime (acid reflux) -sodium chloride 0.65% nasal spray; administer one spray into each nostril as needed for congestion -sodium chloride 1,000 mg; take one tablet by mouth two times a day with meals (supplement) -sodium chloride-sodium bicarbonate nasal rinse; administer one application into each nostril two times a day for stuffy nose -trazodone 50 mg; take 25 mg; by mouth at bedtime as needed for sleep R1's Medication Administration Record (MAR) dated December 2024, included the following medications: -acetaminophen 500 mg; take two tablets by mouth twice a day -per prescriber orders listed above R1 should receive acetaminophen three times a day -atorvastatin 80 mg; take one tablet by mouth at bedtime -brimonidine 0.2%; administer one drop into the right eye two times daily -centrum silver; take one tablet by mouth daily -cetirizine 10 mg; take one tablet by mouth daily -ferrous sulfate 325 mg; take one tablet by mouth every other day	01820		

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01820	Continued From page 39 -latanoprost -.005%; instill one drop into left eye at bedtime -metoprolol tartrate 50 mg; take one tablet by mouth twice a day -multivitamin-iron-FA-CA-minerals 400 mcg; take one tablet by mouth daily -N M magnesium glycinate 100 mg; take four capsules by mouth twice a day -per prescriber orders listed above R1 should receive 500 mg by mouth twice a day -nystatin 100,000 unit/g cream; apply one application to groin and coccyx twice a day -sodium chloride 1 g; take one tablet by mouth two times a day with meals -trazodone 50 mg; take 25 mg by mouth at bedtime R1's MAR did not include: -clopidogrel 75 mg; take one tablet by mouth daily -diclofenac sodium 1% gel; apply four grams (g) four times a day to painful joints and back -megestrol 40 mg/milliliter (ml) solution; take 5 ml (200 mg) total by mouth two times a day -pantoprazole 40 mg; take one tablet by mouth at bedtime -sodium chloride 0.65% nasal spray; administer one spray into each nostril as needed for congestion -sodium chloride-sodium bicarbonate nasal rinse; administer one application into each nostril two times a day for stuffy nose On December 4, 2024, at 11:49 a.m., clinical nurse supervisor (CNS)-B stated the medications not included on R1's MAR had either been discontinued or R1's family did not want her to take anymore. CNS-B stated R1's record lacked prescriber orders to discontinue these medications. CNS-B further stated she could not locate the updated prescriber orders for R1's	01820		

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01820	Continued From page 40 acetaminophen and magnesium glycinate orders. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated the registered nurse was responsible for assuring that current, authorized prescriber prescriptions for medications and orders for treatments and therapies, to be administered by the staff were kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 interview and record review, the facility failed to renew prescriptions at least every 12 months for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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).	01830		

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01830	Continued From page 41 The findings include: R2's record lacked an annual renewal of prescriber orders for medications. R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. R2's service plan dated June 6, 2024, indicated R2 received assistance with medication administration. R2's most current prescriber orders were requested. Prescriber orders dated May 1, 2023, were provided. The following physician orders lacked evidence of being renewed annually: -calcium antacid 500 mg; chew and swallow two tablets by mouth twice a day -clonazepam 0.5 mg; take one tablet by mouth daily -Flintstones complete tablet; chew and swallow one tablet by mouth twice daily -fluticasone 50 micrograms (mcg) spray; inhale two sprays into each nostril twice daily -Incruse Ellipta 62.5 mcg/inhaler; inhale one puff by mouth daily -Ingrezza 40 mg; take one capsule by mouth daily -ipratropium 0.03% nasal spray; instill two sprays into each nostril twice daily -levothyroxine 137 mcg; take one tablet by mouth once daily -omeprazole 40 mg; take one capsule by mouth every morning before breakfast -pregabalin 100 mg; take one capsule by mouth twice daily -refresh tears; instill one drop in both eyes every	01830		

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01830	Continued From page 42 four hours while awake. Use 15 minutes after Restasis dose -vitamin D3 25 mcg; take three tablets by mouth daily -nystatin 100, 000 unit/g powder; apply topically to affected areas twice daily -celecoxib 200 mg; take one tablet by mouth once a day -docusate sodium liquid 16 ounces (oz); take 5 ml by mouth once a day -divalproex 125 mg; take 8 capsules by mouth at bedtime -atorvastatin 20 mg; take one tablet by mouth once a day -acetaminophen 500 mg; take two tablets by mouth every 6 hours as needed for pain or fever -albuterol 0.083%; inhale one vial orally via nebulizer every six hours as needed for wheezing or shortness of breath -furosemide 20 mg; take one tablet by mouth daily as needed for shortness of breath/leg swelling -hydrocortisone 2.5 % rectal cream; insert one application into the rectum four times a day as needed for hemorrhoids -ipratropium/albuterol 0.5-3 mg/3 ml inhalation; inhale one vial via nebulizer four times daily as needed for wheezing or shortness of breath -Miralax 17 g; dissolve 17 g in 8 oz of liquid daily as needed for constipation -ondansetron 4 mg; take one tablet by mouth every 8 hours as needed for nausea or vomiting -oxycodone 5 mg; take one half tablet (2.5 mg) or two half tablets (=5 mg) depending on pain level every 4 hours as needed -Proair Respiclick 90 mcg; inhale two puffs by mouth every four hours as needed for wheezing -Ventolin HFA 90 mcg; inhale two puffs by mouth every four hours as needed for shortness of breath or wheezing	01830		

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01830	Continued From page 43 On December 4, 2024, at 12:14 p.m., corporate clinical nurse supervisor (CCNS)-G stated R2's prescriber orders listed above had not been renewed at least annually as required. CCNS-G stated they were waiting for R2's primary care provider to return their request for annual prescriber orders. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated the registered nurse would assure that prescriber renews a medication prescription or treatment or therapy order at least every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 44 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R4). 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 was admitted to the licensee on May 26, 2019, and discharged on August 22, 2024. R4's discharge summary dated August 27, 2024, indicated R4 received assistance with medication management. R4's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the	01910		

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01910	Continued From page 45 disposition. On December 4, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated R4's disposition of medications could not be located in R4's record. The licensee's Content of Client's Medication Record policy, undated, indicated the client's record would contain the following information about the client's medications: -documentation of the disposition of any medications that the agency was managing when the medications were discontinued, expired, or when the client's medication management services were terminated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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	01940		

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01940	Continued From page 46 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory	01940		

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01940	Continued From page 47 failure. On December 3, 2024, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D disconnect R2's BIPAP (noninvasive breathing device that helps people with breathing difficulties) machine and apply oxygen per nasal cannula. R2's service plan dated June 6, 2024, indicated R2 received assistance with ace wraps, brace, compression stockings, exercises, oxygen management, INR monitoring (blood test that measures how long it takes for your blood to clot). The service plan did not include BIPAP services. R2's signed prescriber orders dated November 25, 2024, included: -warfarin 5 milligrams (mg); take 5 mg on Thursday and Sunday -warfarin 6 mg; take 6 mg on Tuesday, Wednesday, Friday and Saturday -re-check INR on December 2, 2024 R2's record lacked prescriber orders for the following treatments: -oxygen -BIPAP -compression stockings -lymphedema wraps R2's Individualized Treatment and Therapy Plan dated June 5, 2024, included: -skin care daily -oxygen management: Oxygen 1-2 liters per nasal cannula. Resident has orders for O2 at 1-2 liters if O2 saturations are below 90. But she chooses to wear O2 continuous at this time. Staff to help her turn concentrator on and off. -oxygen saturation checks daily	01940		

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01940	Continued From page 48 -ACE wraps: Use ACE wraps to wrap legs. Remove compression wraps in the PM. R2's Individualized Treatment and Therapy plan did not include a statement of the type of services being provided, compression stockings, lymphedema wraps, BIPAP or INR checks. R2's Individualized Treatment plan also lacked documentation of specific resident instructions relating to R2's oxygen and when to administer 1 liter of oxygen or 2 liters of oxygen. R3 R3 was admitted on March 4, 2024, with diagnoses that included diabetes. On December 2, 2024, at 11:25 a.m., the surveyor observed ULP-C check R3's blood sugar. R3's service plan dated October 8, 2024, indicated R3 received assistance with dressing, shower assistance, hygiene assistance, blood glucose checks, INR monitoring, and medication administration. The service plan did not include medication set up services. R3's signed prescriber orders dated July 26, 2024, included: -blood glucose checks five times a day. R3's signed prescriber orders dated November 21, 2024, included: -warfarin 4 mg by mouth daily, re-check INR on December 3, 2024. R3's Individualized Treatment and Therapy Plan dated March 4, 2024, included: -blood glucose checks five times daily.	01940		

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01940	Continued From page 49 R3's Individualized Treatment and Therapy Plan did not include a statement of the type of services being provided, INR checks. On December 4, 2024, at 12:23 p.m., clinical nurse supervisor (CNS)-B stated R2 and R3's individualized treatment plan lacked the required content as noted above. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated: -the provider would develop and maintain a current individualized treatment and therapy management record for each resident which must contain a statement of the type of services that will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960		

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01960	Continued From page 50 by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. R2's service plan dated June 6, 2024, indicated R2 received assistance with ace wraps, brace, compression stockings, exercises, oxygen management, INR monitoring (blood test that measures how long it takes for your blood to clot). The service plan did not include BIPAP services. R2's signed prescriber orders dated November 25, 2024, included: -warfarin 5 milligrams (mg); take 5 mg on Thursday and Sunday -warfarin 6 mg; take 6 mg on Tuesday, Wednesday, Friday, and Saturday -re-check INR on December 2, 2024 R2's record lacked prescriber orders for the	01960		

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01960	Continued From page 51 following treatments: -oxygen -BIPAP -compression stockings -lymphedema wraps On December 3, 2024, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D disconnect R2's BIPAP (noninvasive breathing device that helps people with breathing difficulties) machine and apply oxygen per nasal cannula to R2. R2's record lacked documentation of BIPAP services and INR checks. R3 R3 was admitted on March 4, 2024, with diagnoses that included diabetes. R3's service plan dated October 8, 2024, indicated R3 received assistance with dressing, shower assistance, hygiene assistance, blood glucose checks, INR monitoring, and medication administration. The service plan did not include medication set up services. R3's signed prescriber orders dated July 26, 2024, included: -blood glucose checks five times a day. R3's signed prescriber orders dated November 21, 2024, included: -warfarin 4 mg by mouth daily, re-check INR on December 3, 2024. On December 2, 2024, at 11:25 a.m., the surveyor observed ULP-C check R3's blood sugar.	01960		

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01960	Continued From page 52 R3's record lacked documentation of INR checks. On December 4, 2024, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated R2 and R3's record lacked documentation of the services listed above. The licensee's Content of the Resident Record policy, undated, indicated the resident record would include documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970		

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01970	Continued From page 53 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: R2 was admitted on May 31, 2022, with diagnoses that included chronic respiratory failure. On December 3, 2024, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D disconnect R2's BIPAP (noninvasive breathing device that helps people with breathing difficulties) machine and apply oxygen per nasal cannula. R2's service plan dated June 6, 2024, indicated R2 received assistance with ace wraps, brace, compression stockings, exercises, oxygen management, and INR monitoring (blood test that measures how long it takes for your blood to clot), and medication administration. The service plan did not include medication set up or BIPAP services. R2's Service Recap Summary dated December 2024, indicated R2 received assistance with the following: -oxygen management three times a day -ACE wraps twice a day -apply brace twice a day R2's record lacked prescriber orders for the following treatments: -oxygen	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30489	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTTER RIDGE	1971 NEAL STREET RED WING, MN 55066

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01970	Continued From page 54 -BIPAP -compression stockings -lymphedema wraps On December 4, 2024, at 12:24 p.m., clinical nurse supervisor (CNS)-B state R2 did not use ACE wraps or a brace but instead wore bilateral compression stockings and lymphedema wraps. CNS-B further stated R2's record lacked prescriber orders for oxygen, BIPAP, compression stocking and lymphedema wraps. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, indicated the registered nurse (RN) would assure that a current, authorized prescriber prescription for medications and orders for treatments and therapies, to be administered by the staff were kept in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable	02310		

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02310	Continued From page 55 health care and medical or nursing standards for one of one resident (R1) with bed rails. This resulted in an immediate correction order issued on December 4, 2024. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included muscle weakness and osteoarthritis. R1's Service Plan dated October 28, 2024, included daily reminders, dressing, escort services, personal assistance, shower assistance, and medication administration. On December 2, 2024, at 12:46 p.m., R1's bed was observed with a rectangle shaped assist bar, which was secured on the right side of the bed. On December 2, 2024, at 12:50 p.m., R1 stated her family brought the bed rail in for her and she used it to get in and out of bed independently. R1's Admission Assessment dated September 26, 2024, indicated R1's family bought and installed R1's bed rail. R1's Bed Safety Assessment dated October 28, 2024, indicated R1 used the bed rail to assist with transfers, turning and repositioning. The assessment indicated R1 had been educated on	02310		

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02310	Continued From page 56 the risk and benefits of using bed rails. R1's record lacked evidence of the following: - manufacturer instructions for the bed rail - evidence the bed rail was installed, used, and maintained per manufacturer's guidelines - evidence of checking the Consumer Product Safety Commission (CPSC) for recalls On December 4, 2024, at 1:05 p.m., executive director (ED)-A stated they did not have the manufacturer's instructions for R1's bedrail and had not checked for safety recalls of the bed rail. The licensee's Assessing the Safety of Side Rails Policy, undated, indicated the following: 1. The registered nurse (RN) will train staff to be alert for any side rail or equipment that resembles a siderail that a client [resident] may be using or considering using and to notify the RN immediately about the side rail or equipment. 2. When notified that a client [resident] has a side rail, the RN will assess and evaluate what the client's [resident] needs are and assess to determine if the client [resident] can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. 3. The RN will provide for any client [resident] who has a side rail or is considering obtaining one and, if appropriate, the RN will educate the client's [resident] representative and/or the client's [resident] family regarding side rail safety and risk including potential death due to falls, entrapment, and asphyxiation. If the RN determines that the client [resident] is not able to safely use a side rail, or that the client's [resident] side rail does not meet the FDA or most current safety guidelines, the RN will recommend that he side rails should be removed and will document	02310		

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02310	Continued From page 57 this recommendation, will document to whom the education was directed and will document the person who was give the recommendation to remove the side rail. 4. If the RN determines that the side rails are not a safe device for the client [resident], the RN will provide options and alternatives for reducing fall or positioning self to the client [resident], the client's [resident] representative and/or the client's [resident] family. The RN will document these recommended options and the response from the client [resident], client's [resident] family and client's [resident] representative to the RN's recommendations. 5. The RN may not remove a side rail that is the property of the client [resident], the client's [resident] representative or the client's [resident] family. If the RN determines that a client's [resident] siderail is unsafe, and the client [resident], the client's [resident] representative or the client's [resident] family does not remove it, the RN will notify the client's [resident] physician and consider whether to notify MAARC. 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". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently	02310		

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02310	Continued From page 58 Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On December 4, 2024, the licensee impletemented actions to mitigate the risk to R1. Scope and severity remains at G.	02310		

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03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. 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 finding include: On December 2, 2024, at approximately 9:00 a.m. upon arriving at the establishment, the surveyor observed the incorrect electronic monitoring notice posted on at the entrance to the licensee's facility, which read: "Electronic Monitoring may be occurring on this property." On December 2, 2024, at 9:49 a.m., executive	03090		

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03090	Continued From page 60 director (ED)-A stated the sign was posted at the front door did not include the following statement "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities". The licensee's Required Postings policy, undated, indicated a sign is posted at the main entrance stating "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, Lodging
3425 40th Ave NW
Rochester
507-206-2721

Type: Full
Date: *12/02/24*
Time: 09:13:07
Report: 8074241223

Food and Beverage Establishment Inspection Report

Location:
Potter Ridge
1971 Neal Street
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038867
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513881546
ID #:

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

The following orders previously issued between 10/11/21 and 01/31/24 have NOT been corrected.

5-200C Plumbing: Maintenance, fixture location

5-205.13

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

water filter last dated 2018

1/31/24: no date on filter, one filter 2022

12/2/24: reissued, no date.

Issued on: 10/11/21 *Comply By: 10/20/21*

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

microwave has an abundance of food debris

12/2/24: reissued

Issued on: 01/31/24 *Comply By: 01/31/24*

Type: Full
Date: *12/02/24*
Time: 09:13:07
Report: 8074241223
Potter Ridge

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Floors under equipment and wall behind dish machine and handwashing sink dirty.

12/2/24: reissued, floors behind tables, under dishmachine

Issued on: 01/31/24 *Comply By: 01/31/24*

The following orders were issued during this inspection.

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

The side of dish machine caulking failing, replace.

Comply By: 12/02/24

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: three compartment dispenser
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: turkey
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: meatball
Violation Issued: No

Process/Item: Work Top Cooler
Temperature: 38 Degrees Fahrenheit - Location: dressing
Violation Issued: No

Process/Item: Hot Holding
Temperature: 156 Degrees Fahrenheit - Location: potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 77 Degrees Fahrenheit - Location: soup (not done)
Violation Issued: No

Type: Full
Date: *12/02/24*
Time: 09:13:07
Report: 8074241223
Potter Ridge

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 202 Degrees Fahrenheit - Location: pork chop
Violation Issued: No

Process/Item: Cooking
Temperature: 123 Degrees Fahrenheit - Location: soup (not done)
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

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 8074241223 of 12/02/24.

Certified Food Protection Manager: Alondra Gabriela Urzua

Certification Number: FM115892 Expires: 03/23/26

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Establishment Representative

Andrea Kieffer

Rochester District Office