Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 15, 2024

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: License Number 417211
Health Facility Identification Number (HFID) 30601
Project Number(s) SL30601015

Dear Licensee:

On October 10, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed April 13, 2023, and follow-up surveys completed on August 11, 2023; November 15, 2023; January 17, 2024 and May 30, 2024. The October 10, 2024, follow-up survey found the facility to be in compliance. Based on these findings, the condition(s) on the license were removed effective October15, 2024.

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

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 25, 2024

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Conditional License Number 417211
Health Facility Identification Number (HFID) 30601
Project Number(s) SL30601015

Dear Licensee:

On May 30, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found not corrected at the time of the follow-up surveys completed on January 17, 2024, November 15, 2023 and August 11, 2023, pursuant to the survey completed on April 13, 2023. Based on this follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is extending the conditional assisted living facility license for Summit Ridge Place for an additional 90 days, due to expire on **October 23, 2024**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey, completed on January 17, 2024, found not corrected at the time of the May 30, 2024, follow-up survey and subject to penalty assessment is as follows:

1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on May 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

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 and immediately correct any reissued orders 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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.

CONDITIONAL LICENSE ISSUED:
MDH will extend the conditional assisted living facility license for Summit Ridge Place for an additional 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Summit Ridge Place is in substantial compliance.

The following condition has been rescinded, effective July 25, 2024:

- No new admissions

In addition, the following conditions will continue to be in effect on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **Consultant:** Summit Ridge Place will continue to contract with an RN to provide consultation concerning all resident(s) to whom Summit Ridge Place provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Summit Ridge Place. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must continue to not have any affiliation with Summit Ridge Place and will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Summit Ridge Place in an effort to help Summit Ridge Place align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Summit Ridge Place will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

c. **Reports:** The RN consultant will continue to provide MDH with regular reports on a weekly basis until MDH notifies Summit Ridge Place and the RN consultant about a change. Each report will be electronically submitted to Carrie Euerle, Investigator Supervisor, State Rapid Response Team, Health Regulation Division, at

carrie.euerle@state.mn.us. Carrie Euerle can be reached at 651-242-8846 (office) with questions about reports. The content of the reports will continue to include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

d. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Summit Ridge Place to correct the violations cited during the follow-up survey as well as to determine the overall practice of Summit Ridge Place in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

e. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

f. **Corrective Action Plan:** Summit Ridge Place will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Summit Ridge Place is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Summit Ridge Place is in substantial compliance on the follow up survey, MDH will remove the conditions from Summit Ridge Place's assisted living facility license, and Summit Ridge Place will correct any outstanding

violations identified during the survey. If Summit Ridge Place is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Carrie Euerle directly at: 651-242-8846.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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 SL30601015 On May 20, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 13, 2023, and a revisit surveys completed on August 11, 2023, November 14, 2023, and February 23, 2024. At the time of the survey, there were 14 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is re-issued for SL30601015 tag identification 1640.	{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	

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{0 000}	Continued From page 1	{0 000}	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{01640} SS=I	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 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 interview and document review, the facility failed to implement and provide services as required by the current service plan for fourteen of fourteen residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14) when services including toileting, transfer assistance, dressing, grooming, behavior management, and scheduled safety checks were	{01640}		

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{01640}	Continued From page 2 not documented and/or provided by facility staff. 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: On May 20, 2024, at 10:10 a.m., the Minnesota Department of Health (MDH) investigator initiated a follow-up visit with the licensee. The investigator initiated an entrance conference with the licensed practical nurse (LPN)-A. LPN-A explained that the assisted living director in residence (ALDIR)-B just left the facility and would be back in a few minutes. LPN-A indicated she was not involved in the plan of correction but the registered nurse (RN)-D, corporate staff, and ALDIR-B had been working on the plan of correction related to previous citations issued at the facility. Upon ALDIR-B's return to the facility, an entrance conference was initiated with ALDIR-B on May 20, 2024, at 10:36 a.m. ALDIR-B stated he was aware of previously cited issues and handed the investigator a 3-ring binder with the licensee's current plan of correction (POC) and associated documentation of action taken to correct previous citations. ALDIR-B also contacted a corporate regional director of operations (RDO)-C to inform them of the follow-up visit and had the investigator speak with RDO-C about requests for documentation and questions regarding the	{01640}		

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{01640}	Continued From page 3 follow-up visit be directed through RDO-C. ALDIR-B stated that over the last two months, RDO-C was heavily involved in completing the plan of correction and training him into the assisted living director role. The licenee's Plan of Correction (POC) document dated May 17, 2024, included under the "Plan of Action" section that the licensee would review RTASKS (electronic documentation system) weekly and discuss with unlicensed personnel (ULP) if tasks (services) were missed. The POC document indicated the director (ALDIR-B) and RDO would print a report weekly for 3 weeks. Then print the report on Mondays, Wednesdays, and Fridays after that and would end on April 12th. The POC included that on May 17, 2024, a checklist was initiated for each shift to verify that all tasks were signed off and included "on May 13 and 14th at 10:00 a.m. the internet was down. Manually charted on document. Checklist was created to ensure services and can go back into RTasks to chart services". The POC indicated that the registered nurse (RN) and director were responsible for these actions. There was no evidence provided of the manually charted services and the manually charted services were not provided in the POC binder presented to the investigator. Review of documentation provided in the licencee's May 17, 2024, POC identified several documents printed off of the RTASKS system. The documents included services that were missed (not documented and/or not completed) and printed out under the title "Missing Services/Chores - Last 72 Hours" and contained the date, time, resident name, and missed service.	{01640}		

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{01640}	Continued From page 4 The MDH investigator requested the most recent RTask report of missed services from the last 72 hours and a May 20th, 2024, report was provided to the investigator by LPN-A. The Missing Services report included 10 missed services for 5 residents (R2, R9, R10, R11, R12) during the AM shift on May 18, 2024, and included the following: - R2 missed blood pressure recording, behavior management for agitation, and behavior management for resistive tendancies. -R9 missed behavior management services for resistive tendancies and behavior management for sexual inappropriateness -R10 missed behavior management for resistive tendancies and symptom management for withdrawals. -R11 missed behavior management and hoarding behavior management. -R12 missed behavior managemnt for reisistive tendancies. Below the documentation of missed services included a hand-written note, signed by LPN-A, dated May 20, 2024, that stated "spoke with staff at 10:45 a.m. [Resident] refused to do B/P [blood pressure]. Will chart when staff returns to afternoon. The note did not indicate who the staff member was who did not complete the tasks and included no information on any action taken to verify if the services were completed and no additional monitoring of the resident's after it was discovered the documentation was not completed. There was no evidence of follow-up being competed prior to May 20th, or prior to the MDH investigator's request for the information. The MDH investigator reviewed all documentation of missed services contained within the facility provided POC. The POC contained the following documentation of Missing Services/Chores - Last	{01640}		

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{01640}	Continued From page 5 72 Hours: -Missing Services/Chores - Last 72 Hours- printed on May 6, 2024, contained a total of 33 missed chores and services for the date of May 5, 2024, and nine missed services for May 6, 2024. May 5, 2024 included missed chore documentation for the AM shift of two chores (medication charting and cleaning) and contained 31 missing resident services for the following 11 residents: R1, R2, R3, R4, R6, R7, R9, R10, R11, R13, R14. The missing services included safety checks, behavior management, toileting assistance, and vital sign recording. The Missing Services/Chores for May 6, 2024 included 9 services were missed for the following residents: R1, R2, R3, R4, R5, R7, R8, R12. The missing services included safety checks, behavior management, and toileting assistance. Handwritten on the right side of the document included that "services were completed internet was down for most shift" signed May 6, 2024, by ALDIR-B. The note did not indicate who the staff members were who did not complete or document the tasks and included no information on any action taken to verify if the services were completed and no additional monitoring of the residents after it was discovered the documentation was not completed. There was no indication or verification of any documentation made or created via paper due to the concern of the internet not being available. -Missing Services/Chores - Last 72 Hours- printed on April 29, 2024, included April 28, 2024 of one missed chore of charting on PM medications and a PM safety check for R1. Handwritten on the document included "spoke with staff and he forgot to chart these services but services were completed" signed by ALDIR-B	{01640}		

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{01640}	Continued From page 6 with a date of April 29, 2024. The note did not indicate who the staff member was who did not complete the tasks and included no information on any action taken to verify if the services were completed and no additional monitoring of the residents after it was discovered the documentation was not completed. -Missing Services/Chores - Last 72 Hours- printed on April 22, 2024, indicated 11 services were missed on April 20, 2024 and one service was missed on April 22, 2024. On April 20, 2024 missed services included overnight behavior management and laundry for R2, R4, R9, R10, and R13. April 22, 2024 contained a missed blood pressure (vital sign) recording for R6. Handwritten on the right side of the document included "these services were done and staff forgot to chart. I spoke to the both staff" signed by ALDIR-B with a date of April 22, 2024. The note did not indicate who the staff member was who did not complete the tasks and included no information on any action taken to verify if the services were completed and no additional monitoring of the residents after it was discovered the documentation was not completed. -Missing Services/Chores - Last 72 Hours-printed on April 15, 2024, indicated 79 services were missed between April 12, April 13, and April 14, 2024. On April 12, 2024, six services were missed which included cleaning, laundry, behavior management, transfer assistance, and wheelchair use, all on the overnight shift for R7 and R8. On April 23, 2024, nine services were missed on the overnight shift which included behavior management, transfer assistance, wheelchair use, and cleaning for R1, R7, and R8. On April 14, 2024, 64 services were missed over the PM and Overnight shift. Services missed	{01640}		

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{01640}	Continued From page 7 included cleaning, laundry, meal reminders, dressing, garbage removal, behavior management, grooming, activity assistance, transfer assistance, escort/mobility assistance, housekeeping, toileting reminders, deep room clean, linen changes, and compression stocking assistance for R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R14. Handwritten to the right of the document included "Spoke with staff and chores were completed" dated April 15, 2024, signed by ALDIR-B. The note did not indicate who the staff members were who did not complete the tasks and included no information on any action taken to verify if the services were completed and no additional monitoring of the residents after it was discovered the documentation was not completed. During an interview with LPN-A at 11:00 a.m. on May 20, 2024, LPN-A was asked about the missing services from the Missing Services Document dated May 20, 2024, that she provided to the investigator. LPN-A indicated that getting staff to sign off on services has "been a problem. We keep calling and are after them... but they [staff] haven't been great at it. It's something we have been working". LPN-A stated that there had been no action taken against the employees who did not chart but RDO-C had said they woud start doing discipline if they continue to not chart. During an interview with RN-D at 12:17 p.m. on May 20, 2024, RN-D indicated she was the nurse in charge of three different facilities. RN-D recently assumed the role of RN in this building and was involved in educating staff, orientating new staff, and was involved in creating and implementing the facility's POC, together with ALDIR-B and RDO-C. RN-D stated ALDIR-B was in charge of printing off the missing services over	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01640}	Continued From page 8 the last 72 hours and in charge of contacting staff if services were missed and following up on any missed services and she was informed by ALDIR-B if there were any missed services. RN-D confirmed she was contacted today (May 20, 2024) about the latest print out of missed services from May 18, 2024, and that an employee forgot to chart on services. RN-D stated she was aware that this was a continuous issue and reminding staff to chart or calling them after their shift about them not charting was "not working" and staff needed to be more aware of the expectation to chart all services, so RN-D recently implemented a new paper checklist for staff to review and sign off on to verify all services were completed and signed off on by each shift during their shift to shift report, and that no employee was allowed to leave the building until this checklist was completed and all services were signed off on. RN-D stated she educated staff about this change and implemented this change on May 9, 2024, and LPN-A was supposed to monitor and check the sheet to ensure it was completed. However, RN-D provided the investigator the document and the checklist was not completed and left blank for several shifts from May 9, 2024 through May 20, 2024. RN-D verified this checklist was not completed and was not being implemented by staff and there had been no follow up to the implementation of this process since it was initiated on May 9, 2024. RN-D stated that at this time no staff had recieved any disciplinary action due to their lack of charting but it was something that was going to be intiated soon. During an interview with ALDIR-B at 1:27 p.m. on May 20, 2024, ALDIR-B confirmed he was in charge of ensuring the facility's POC was implemented and had been printing out lists of	{01640}		

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{01640}	Continued From page 9 missed services over the lat 72 hours and following up with staff. ALDIR-B confirmed there were occasions were staff had not documented tasks. ALDIR-B stated when he noticed services missed, he contacted staff, asked them if they completed the services, they always said they did and forgot to chart, so ALDIR-B signed off next to the printed list of missed services that services were completed. ALDIR-B could not provide any further documentation or verfication to support that the services were completed but stated staff said they were and they forgot to chart, so during their next shift, staff would come in and sign off on the services. ALDIR-B confirmed he did not verify if the services were actually completed other than contacting staff and asking them. ALDIR-B stated no disciplinary action had been taken with any current employees over their lack of documentation or lack of completing services, but RDO-C had told him that would be the next steps if staff continued to not document. ALDIR-B also brought up a concern of an internet outage and was coming up with a system to document if this happened again, but this had not been implemented. ALDIR-B also had some concerns about the possibility of the electronic system being slow to update on if the services were documented but had not contacted the company, just thought he may have noticed that and it was not confirmed. ALDIR-B confirmed no action had been taken related to looking into the software company if this was an issue or any documentation of this issue having occurred. ALDIR-B confirmed that the services missed on the documentation provided to the investigator today (May 20, 2024) for the missed May 18, 2024, was not signed off by the employee (unlicensed personnel/ULP-E) because ULP-E got busy and forgot. ALDIR-B stated that he contacted ULP-E and ULP-E stated he forgot to	{01640}		

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{01640}	Continued From page 10 sign out the services but that the services were completed. ALDIR-B stated he was planning to document and provide disciplinary action to ULP-E due to this charting error. ALDIR-B confirmed that staff struggled with documentation of services and since he started at the facility he has recognized this problem and tried to work on it but staff continued to struggle in this area and had discussed with RDO-C that disciplinary action may need to be taken for staff who continue to miss documentation. The POC was reviewed with ALDIR-B regarding the other dates of missed services that he signed off on and documented as completed. ALDIR-B indicated that following each of these discussions with employees he reminded employees of the importance of charting and went over documenting again with employees on a May 9th meeting and even implemented a new checklist. ALDIR-B also verified the checklist was not being completed by staff and was not being monitored by anyone to ensure staff were completing the checklist. ALDIR-B stated he planned to do more supervising of staff and start disciplinary action to ensure staff get committed to charting the services provided. ALDIR-B confirmed that the expectation of staff is to complete services per the service plans and document services as provided. During an interview with ULP-E at 2:57 p.m. on May 20, 2024, ULP-E was asked about missing services from May 18, 2024. ULP-E verified that he did not sign off on the services and that it was not due to a computer glitch or software issue but that he got busy with a resident and did not go back and review his charting before the end of his shift. ULP-E stated he did not sign of on the services because he did not review charting as he ended up staying an extra 30 minutes with a	{01640}		

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{01640}	Continued From page 11 resident and his shift was over, so he didnt go back to review charting, but stated the services were completed. ULP-E could not provide verification to support if the services were completed. The facility's Service Plan Policy, dated August 1, 2021, indicated the licensee would implement and provide all services indicated in the service plan. No further information was provided.	{01640}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

March 15, 2024

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Conditional License Number 412492
Health Facility Identification Number (HFID) 30601
Project Number(s) SL30601015 and HL306015963M / HL306014768C
and HL306015964M / HL306015070C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey and follow-up complaint investigation on January 17, 2024, to determine correction orders found not corrected during the follow-up surveys and follow-up complaint investigations completed November 15, 2023, and August 11, 2023, pursuant to the survey completed April 13, 2023, and complaint investigation completed March 21, 2023. Based on the follow-up survey results you were found to continue to not be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day extension to the conditional license due to expire on **June 13, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,000.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 2320 - 144g.91 Subd. 4 (b)Appropriate Care And Services - $3,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

However, in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey, completed on November 15, 2023, found not corrected at the time of the January 17, 2024, follow-up survey and/or subject to penalty assessment is as follows:

St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on January 17, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Summit Ridge Place an extension to the conditional assisted living facility license for an additional 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Summit Ridge Place is in substantial compliance.

The following condition is being re-instated and will remain in effect through the extended conditional assisted living facility license period:

a. **No new admissions:** Summit Ridge Place will not admit any new residents under its extended conditional assisted living facility license until MDH removes the "no new admissions" condition. Summit Ridge Place must provide the Department:

    i. A list of the names and birthdates of any individuals Summit Ridge Place is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

In addition, the following conditions will continue to remain in effect through the extended conditional assisted living facility license period:

b. **No new substantiated maltreatment allegations:** If any new investigations begin in the extended conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

c. **Consultant:** Summit Ridge Place will continue to contract with an RN to provide consultation concerning all resident(s) to whom Summit Ridge Place provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Summit Ridge Place. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH.

The RN must continue to not have any affiliation with Summit Ridge Place. Summit Ridge Place will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Summit Ridge Place in an effort to help Summit Ridge Place align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Summit Ridge Place will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Summit Ridge Place and the RN consultant about a change. Each report will continue to be electronically submitted to Carrie Euerle, Investigation Supervisor, State Rapid Response Team, Health Regulation Division, at carrie.euerle@state.mn.us. Carrie Euerle can be reached at 651-242-8846 (office) with questions about reports. The content of the reports will continue to include information such as:

   i. Progress towards correction of orders;
   ii. Observations of staff delivering assisted living services and the level of competency observed;
   iii. Conversations with residents and family members about satisfaction with assisted living services;
   iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
   v. Overall impressions about the quality of the assisted living services delivered;
   vi. Overall impressions about the dignity with which the residents and their family members are treated;
   vii. Concerns; and
   viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Summit Ridge Place to correct the violations cited during the follow-up survey as well as to determine the overall practice of Summit Ridge Place in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Summit Ridge Place will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Summit Ridge Place is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the extended 90-day conditional license period. If MDH determines Summit Ridge Place is in substantial compliance on the follow up survey, MDH will remove the conditions from Summit Ridge Place's assisted living facility license, and Summit Ridge Place will correct violations identified during the survey to come into substantial compliance. If MDH determines Summit Ridge Place is not in substantial compliance, MDH may take additional enforcement action against Summit Ridge Place, including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Carrie Euerle directly at: 651-242-8846.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30601015 On February 23, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 13, 2023, and a revisit surveys completed on August 11, 2023, and November 14, 2023. At the time of the survey, there were 13 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders are issued/reissued.	{0 000}	Assisted Living Provider 144G. 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	

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{0 000}	Continued From page 1	{0 000}	USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 470		

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0 470	Continued From page 2 licensee failed to implement a staffing plan to ensure sufficient staffing to meet the scheduled and foreseeable unscheduled needs and promptly and effectively respond to resident emergencies for eight of eight residents (R1, R2, R3, R4, R5, R6, R7, R8) when the night shift was not staffed according to the staffing plan and new staff were utilized to provide care before being trained or orientated to residents or the facility. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 24, 2023, noted that two unlicensed direct care staff were typically scheduled for the night shift. The facility's Direct Care Staffing Plan dated September 15, 2023, indicated staff have the experience, training, and competency to provide care and services to residents as appropriate to their position. Unlicensed personnel (ULP) receive the required orientation and annual training and competency evaluation per training policy. ULP receive additional training and competency evaluation for additional nurse delegated tasks as needed and based on the residents' assessment and service plan. Under	0 470		

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0 470	Continued From page 3 the evaluation of the direct-care staffing plan identified the following average number needed for ULPs on the Day, Evening, and Night shift as 2 ULPs. ULP-B's personnel file indicated a hire date of February 19, 2024, and a background check completed on February 19, 2024. There was no evidence of initial training provided to ULP-B on February 19, 2024. The facility's staffing schedule provided by and reviewed with Registered Nurse (RN)-A on February 23, 2024, for the dates of February 20, 2024 and February 21, 2024, reflected two staff were scheduled for the night shift (ULP-B and ULP-D) on the 20th and ULP-B and ULP-F on the 21st. A staffing schedule provided via email on February 29, 2024, identified for February 20th staffing to include ULP-B, ULP-C, and ULP-D, and February 21 included ULP-B, ULP-C, and ULP-F. ULP-B's employee file indicated orientation, delegation, and training was not completed with ULP-B until February 23, 2024. During interview with Registered Nurse (RN)-A on February 23, 2024, at 3:00 p.m. RN-A confirmed ULP-B worked during the night shift on February 20th and 21st during her first two days of employment and prior to her receiving training. RN-A indicated she was on a planned leave of absence until February 20th and was not aware of concerns with the schedule until she returned. RN-A indicated she expected staff to be trained and to have completed orientation and competency testing prior to working independently. RN-A confirmed ULP-B did not receive training, orientation, or competency	0 470		

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0 470	Continued From page 4 testing before working independently. The Regional Director of Operations (RDO) was interviewed on February 23, 2024, at 3:15 p.m. and confirmed ULP-C was removed from the schedule on February 20, 2024, due to a pending investigation of an alleged mistreatment of a resident and confirmed only two staff worked on February 20th (ULP-B and ULP-D) and February 21 (ULP-B and ULP-F). RDO confirmed the 20th was ULP-B's first day of work and ULP-B was not trained prior to working and did not know if ULP-D or ULP-E were aware if ULP-B was a new staff member and/or told of the need to orientate ULP-B. RDO confirmed that the expectation of the facility was to have three staff scheduled if one person was new and orientating and ULP-B should not have been scheduled to work as the second staff person. RDO stated she was not informed of this staffing change; only the need to remove ULP-C from the schedule. RDO stated the licensed assisted living director (LALD) was responsible for staffing and she was not aware that this change was made to cover for removing ULP-C from the schedule. LALD was interviewed on February 26, 2024 at 1:26 p.m. LALD stated she was not available at the time of the onsite visit on February 23, 2024 as she was on a planned leave of absence. LALD confirmed she was responsible for staffing the facility. LALD indicated she was aware of the schedule created for February 20, and February 21, 2024, and aware that ULP-B was staffed during her first shifts at the facility. LALD indicated on February 20th, she informed RDO of a concern that arose with ULP-C and that she needed to remove ULP-C from the schedule. LALD stated she called RDO about the need to fill the shift and have back up staffing and explained	0 470		

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0 470	Continued From page 5 that ULP-B was a new staff member; that ULP-B was in-training and if she could not find staff she would have to utilize ULP-B as the second staff member. RDO approved this request and approved for LALD to have ULP-B work the shifts on February 20th and February 21st 2024. LALD stated she attempted to fill the shifts with agency staff, but no staff responded to the requests. LALD confirmed the usual staffing would include for two staff to work the night shift, and if training, three staff would be scheduled so one staff would be on orientation and one staff would train the new staff; the new staff would not be counted in the staffing of the facility. LALD stated the facility had trouble with staffing and they were utilizing staffing agencies to fill open shifts and staffing was a concern. LALD indicated she was informed by RDO on February 23, 2024, during her planned leave of absence, that she needed to figure out staffing over the weekend of the 24th and 25th, as corporate staff became aware staffing agencies utilized were not registered with the state. RDO directed LALD it was her job to fill the staffing needs of the building and provided no assistance to LALD to appropriately staff the facility. ULP-B was interviewed on February 29, 2024, at 12:05 p.m. ULP-B stated she contacted the facility and spoke with LALD on February 19, 2024, inquiring about open shifts and if they had any positions available. ULP-B was asked to come in and fill out an application. ULP-B stated she arrived at the facility, filled out an application, and was hired that day. LALD asked ULP-B when she could start training and ULP-B said she was available any time. ULP-B was told to come in the next night and begin training. ULP-B was told she would receive training and orientation before being able to work on her own. When ULP-B	0 470		

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0 470	Continued From page 6 arrived at the facility for her first training shift, an evening shift staff (ULP-E) pulled her aside and told her she would be training with another staff member (ULP-C) during the night shift. ULP-B expected there to be two staff members who showed up for night shift but only one staff came (ULP-C). ULP-B said "they didn't do anything; I wasn't trained at all; they just threw me on the floor without anything." ULP-B said she felt [during the first two shifts] she was doing more work than the staff who were scheduled and were supposed to be training her. ULP-B reported she was not shown how to chart or document and received no training on documentation because she didn't have access to the charting system yet. ULP-B stated that on the 21st she received a call at 5:00 a.m. at the facility, at the end of her shift, from RDO. RDO told her she couldn't work again until she was "delegated tasks" and told ULP-B she had to come back in later that day to do that. ULP-B said she didn't know what "delegated task" meant and RDO didn't provide explanation, just that she had to do it. ULP-B came back on the 23rd (the next day) and received training from RN-A. ULP-B reported her training concerns and observations made during her last shifts to RN-A. ULP-B stated RN-A apologized and said that it shouldn't have happened that way. ULP-B stated she felt RN-A was the only staff member who actually cared and was trying to get things done the right way. ULP-B stated she then worked independently on February 26th, but later received a text from LALD that she could not work until she completed all of her RELIAS training (computer-based training) and did not know when or if she would work again, as she was not provided any further update. The licensee's Employee General Orientation Policy dated December 4, 2023, included that	0 470		

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0 470	Continued From page 7 upon hire and prior to performing any functions of their position at Cornerstone Management Services, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. General orientation will be scheduled to begin immediately upon hire of all new employees and be completed within the specified time frame. Employees should not perform job duties before the completion of orientation to the job including general and safety orientation. The licensee's Staffing & Scheduling policy dated January 31, 2024, noted the clinical nurse supervisor must ensure that staffing levels are adequate to address resident needs as identified in the service plan, each resident's level of acuity, ability of staff to meet the resident's scheduled and reasonably foreseeable unscheduled needs, and according to staff experience, training, and competency. No further information provided. Time Period for Correction: Seven (7) Days	0 470		
{01640} SS=I	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	{01640}		

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{01640}	Continued From page 8 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement and provide services as required by the current service plan for eight of eight (R1, R2, R3, R4, R5, R6, R7, R8) when services including toileting, transfer assistance, behavior management, and scheduled safety checks were not documented and/or provided by the night shift staff. In addition, staff providing services were not informed of the current written service plan as a new staff member was working during the night shift before completing facility orientation and had not been signed off on a list of delegated nursing tasks or competency tested. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	{01640}		

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{01640}	Continued From page 9 The findings include: R1 R1's admitted to the facility on October 27, 2023 with diagnoses of delirium secondary to multiple medical problems and major depressive disorder. R1's medical record indicated R1 eloped from the facility on November 3, 2023, by going out his apartment window. Night shift staff found R1 missing during night shift rounds. R1 returned to the facility the next day. R1's window was secured, an alarm was put on the window, and hourly safety checks were implemented to increase supervision of R1. R1's service plan dated December 26, 2023, included behavior management-elopement threat three times per day and hourly safety checks. R1's progress notes included a note from February 16, 2024, which indicated R1 attempted to leave the facility with his girlfriend. Staff intervened and did not allow R1 to leave. Staff escorted R1 to scheduled transportation pick up to ensure he was brought to scheduled appointment. R1's Individualized Abuse Prevention Plan (IAPP) dated February 21, 2024, indicated R1 was at high risk for elopement due to being unhappy with placement. R1's IAPP indicated R1 eloped from the facility on November 3, 2023, through his apartment window. Comments under the plan of action indicated a window alarm was installed and scheduled safety checks were in place. R1's Services Delivered record from February 20, 2024, indicated an overnight Behavior Management-Elopement Threat service and an	{01640}		

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{01640}	Continued From page 10 11:00 p.m. safety check were not documented or signed off as completed by facility staff. R1's Services Delivered record from February 21, 2024, indicated safety checks at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. were not documented or signed off as completed by facility staff. R2 R2 admitted to the facility on December 5, 2023. R2's IAPP dated December 19, 2023, indicated R2 was at high risk for elopement due to being unhappy with placement in a memory care unit. The IAPP indicated R2 had a history of elopement and had eloped from his previous home. R2's IAPP further identified R2 wandered and walked around the facility constantly while awake. The IAPP also identified R2 as a fall risk and under comments/action plan indicated to provide safety checks. R2's Service Plan dated December 13, 2023, included for 12 (every two hour) safety checks per day. R2's Services Delivered record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. were not documented as completed by staff. R3 R3 admitted to the facility on January 19, 2024, with a diagnosis of dementia. R3's February 1, 2024, IAPP identified R3 as a moderate elopement risk. R3's IAPP identified R3's behavior as an elopement threat due to moderate cognitive impairment. The IAPP also	{01640}		

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{01640}	Continued From page 11 identified R3 as a fall risk and under the comments/action plan included to provide scheduled safety checks to ensure ambulation and transfers are observed and assistance is provided. R3's Service Plan dated January 19, 2024, included behavior management- elopement threat three times per day, transfer assistance three times per day, and toileting assistance nine times per day. R3's Service Plan also included safety checks twelve times (every two hours) per day and PRN (as-needed). R3's Services Delivered record dated February 20, 2024, indicated a scheduled overnight transfer assist and an 11:00 p.m. toileting service were not documented as completed by staff. R3's Services Delivered record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. were not documented as completed by staff. R4 R4 admitted to the facility on January 10, 2024. R4's IAPP dated February 7, 2024, identified R4 as low risk for elopement and identified R4 had not demonstrated exit-seeking behavior. However, the IAPP further included a behavior of 'elopement threat' and included under comments/plan of action: resident wants to leave. The IAPP also identified R4 as a fall risk and under the comments/action plan included to provide scheduled safety checks to ensure ambulation and transfers are observed and assistance is provided. R4's Service Plan dated January 11, 2024,	{01640}		

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{01640}	Continued From page 12 included behavior management- elopement threat three times per day and safety checks twelve (every two hours) times per day. R4's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. R5 R5 admitted to the facility on October 24, 2023. R5's Service Plan dated November 15, 2023, included for safety checks twelve times per day (every two hours) and PRN (as-needed). R5's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff R6 R6 admitted to the facility on March 13, 2023. R6's Service Plan dated September 8, 2024, included for safety checks twelve times per day (every two hours). R6's IAPP dated February 22, 2024, indicated R6 was at risk for falls and under comments/action plan indicated to provide scheduled safety checks. R6's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff R7 R7 admitted to the facility on June 1, 2022.	{01640}		

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{01640}	Continued From page 13 R7's IAPP dated February 12, 2024, identified R7 as at high risk for falls and under the comments/action plan included to provide scheduled safety checks to ensure ambulation and transfers are observed and assistance is provided. R7's Service Plan dated January 22, 2024, included safety checks twelve times per day (every two hours). R7's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff R8 R8 admitted to the facility on October 18, 2023. R8's Service Plan dated October 18, 2023, included safety checks twelve times per day (every two hours) and PRN (as-needed) safety checks. R8's Service Plan also included toileting assistance nine times per day, daily transfer assistance, and daily wheelchair assistance. R8's Services Delivered record dated February 20, 2024, indicated overnight toileting, overnight wheelchair use, and 11:00 p.m. toileting assitance was not documented as completed by staff. R8's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. During interview on February 23, 2024, at 3:00 p.m. Registered Nurse (RN)-A indicated that following R1's elopement on November 3, 2023,	{01640}		

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{01640}	Continued From page 14 the facility completed an internal investigation and identified safety checks were not signed off by the night shift staff during the time R1 eloped. Following the elopement, RN-A completed retraining with all staff on the importance of completing safety checks and documenting the checks. RN-A stated she had since been pulling audits of services that were missed (not documented or not completed) every Monday, Wednesday, and Friday, for a 72-hour look back period to identify any missed services and to follow up with staff who did not complete and/or did not sign off on services. RN-A indicated the most recent audit was completed today (Friday) for a look back period back to February 20, 2024. RN-A identified missed checks and documentation from the night shift staff on February 20, 2024, and February 21, 2024. Upon review of the night shift schedule, RN-A stated the checks may have been missed as a new unlicensed personnel (ULP)-B was working during those shifts. RN-A confirmed services for were not documented by the night shift staff on February 20, 2024, or February 21, 2024, for several residents. RN-A stated she expected all service plans to be followed by facility staff and that all staff documented services as delivered. The Regional Director of Operations (RDO) was interviewed on February 23, 2024 at 3:15 p.m. RDO reviewed with the MDH surveyor the missing services including the missed toileting, behavior monitoring, transfer assistance, and safety checks that were not documented on February 20th and February 21, 2024, and confirmed that staff should have documented if services were provided and that all resident service plans should be followed by staff and services should be documented as completed.	{01640}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01640}	Continued From page 15 The facility's Service Plan Policy, dated August 1, 2021, indicated the licensee would implement and provide all services indicated in the service plan. No further information was provided.	{01640}		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure health care and other assisted living services were provided to eight of eight residents (R1, R2, R3, R4, R5, R6, R7, R8) by staff who were properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan when a new unlicensed personnel (ULP-B) was utilized to work the night shift independently on her first two days of employment before being provided training, orientation, delegation of tasks, or competency tested. This had the potential to affect all residents. 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	02320		

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	30601	A. BUILDING: _____ B. WING _____	R 01/17/2024

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02320	Continued From page 16 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 Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 24, 2023, noted that two unlicensed direct care staff were typically scheduled for the night shift. ULP-B's personnel file included a hire date of February 19, 2024, and a background check completed on February 19, 2024. There was no evidence of initial training or orientation provided to ULP-B on February 19, 2024. The facility's staffing schedule provided by and reviewed with Registered Nurse (RN)-A on February 23, 2024, for the dates of February 20, 2024 and February 21, 2024, reflected two staff were scheduled for the night shift (ULP-B and ULP-D). An additional staffing schedule was provided via email on February 29, 2024, that reflected staffing for February 20th that included ULP-B, ULP-C and ULP-D and for February 21, 2024 that included ULP-B, ULP-C, and ULP-F. ULP-B's employee file indicated orientation, delegation and training was not completed until February 23, 2024. February 20th, 2024 A review of a facility Services Delivered (a document of services provided according to resident service plans) record and Missing Services record indicated on February 20, 2024,	02320		

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02320	Continued From page 17 the night shift failed to provide and/or document services for the following residents: R1 R1 admitted to the facility on October 27, 2023 with diagnoses of delirium secondary to multiple medical problems and major depressive disorder. R1's service plan dated December 26, 2023, included behavior management-elopement threat three times per day and hourly safety checks. R1's services delivered record from February 20, 2024, indicated an overnight Behavior Management-Elopement Threat service and an 11:00 safety check were not documented or signed off by facility staff. R3 R3 admitted to the facility on January 19, 2024 with a diagnosis of dementia. R3's Service Plan dated January 19, 2024, included behavior management- elopement threat three times per day, transfer assistance three times per day, and toileting assistance nine times per day. R3's Service Plan also included safety checks twelve times (every two hours) per day and PRN (as-needed). R3's Services Delivered record dated February 20, 2024, indicated a scheduled overnight transfer assist and an 11:00 p.m. toileting service were not documented by staff. R8 R8 admitted to the facility on October 18, 2023. R8's Service Plan dated October 18, 2023, included safety checks twelve times per day	02320		

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02320	Continued From page 18 (every two hours) and PRN (as-needed) safety checks. R8's Service Plan also included toileting assistance nine times per day, daily transfer assistance, and daily wheelchair assistance. R8's Services Delivered record dated February 20, 2024, indicated overnight toileting, overnight wheelchair use, and 11:00 p.m. toileting assitance were not documented by staff. February 21, 2024 A Review of facility Services Delivered (a document of services provided according to resident service plans) record and Missing Services record indicated on February 21, 2024, the night shift failed to provide and/or document services for the following residents: R1 R1's Services Delivered record from February 21, 2024 indicated safety checks at 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m. and 6:00 a.m. were not documented or signed off as completed by facility staff. R2 R2 admitted to the facility on December 5, 2023. R2's Service Plan dated December 13, 2023, included for 12 (every two hour) safety checks per day. R2's Services Delivered record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. were not documented as completed by staff. R3 R3's Services Delivered record dated February 21, 2024, indicated safety checks for 12:00 a.m.,	02320		

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02320	Continued From page 19 2:00 a.m., 4:00 a.m., and 6:00 a.m. were not documented as completed by staff. R4 R4 admitted to the facility on January 10, 2024. R4's Service Plan dated January 11, 2024, included behavior management- elopement threat three times per day and safety checks twelve (every two hours) times per day. R4's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. R5 R5 admitted to the facility on October 24, 2023. R5's Service Plan dated November 15, 2023, included for safety checks twelve times per day (every two hours) and PRN (as-needed). R5's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. R6 R6 admitted to the facility on March 13, 2023. R6's Service Plan dated September 8, 2024, included for safety checks twelve times per day (every two hours). R6's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff.	02320		

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02320	Continued From page 20 R7 R7 admitted to the facility on June 1, 2022. R7's Service Plan dated January 22, 2024, included safety checks twelve times per day (every two hours). R7's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. R8 R8's Services Delivered Record dated February 21, 2024, indicated safety checks for 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m., were not documented as completed by staff. During interview with Registered Nurse (RN)-A on February 23, 2024, at 3:00 p.m. RN-A confirmed the above services for February 20 and February 21, 2024, were not documented by night shift staff. RN-A confirmed the expectation would be for staff to document services as provided. RN-A confirmed ULP-B worked during the night shift on February 20th and 21st during her first two days of employment prior to receiving training and orientation. RN-A indicated she was on a scheduled leave of absence until February 20th and was not aware of concerns with the schedule until she returned. RN-A indicated she expected staff to be trained and to have completed orientation and be signed off on competency testing prior to working independently. RN-A confirmed ULP-B did not receive training, orientation, or competency testing before working independently. RN-A indicated she was not responsible for scheduling and not aware of the scheduling of ULP-B on her first two days of employment.	02320		

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02320	Continued From page 21 During interview with the Regional Director of Operations (RDO) on February 23, 2024, at 3:15 p.m. RDO indicated she was not aware of ULP-B working independently on her first two days of employment without completing any training or orientation. RDO indicated she was informed by the licensed assisted living director (LALD) on February 20th of an incident involving another employee (ULP-C) and that ULP-C had to be removed from the schedule due to an allegation of mistreatment that required an investigation. RDO stated she was informed by LALD of ULP-C being removed from the schedule but denied being aware of ULP-B being scheduled in ULP-C's place on the schedule. RDO indicated this would not be an appropriate way to fill the shift as ULP-B should not have been working independently and there should have been three staff scheduled if one person was training. When asked if LALD informed RDO of a concern with staffing, RDO denied being informed of ULP-B being a new staff member. RDO stated LALD should have ensured more appropriate staffing. When asked what the expectation would be for LALD to ensure staffing in this scenario, RDO stated she [RDO] should have been informed and she would have assisted in obtaining pool staff or additional staff to fill the staffing need. RDO stated LALD told her a new staff was working but she was "competent and deep into training". RDO confirmed that she oversaw LALD's in eight different facilities, was on-call 24/7 and if an LALD needed help or assistance it would be her job to fill in and help LALD. LALD was interviewed on February 26, 2024, at 1:26 p.m. LALD stated was not available at the time of the onsite visit on February 23, 2024, as she was on a planned leave of absence. LALD	02320		

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02320	Continued From page 22 confirmed she was responsible for staffing the facility. LALD indicated she was aware of the schedule created for February 20 and February 21, 2024, and aware that ULP-B was staffed during her first shifts at the facility. LALD indicated on February 20th she informed RDO of a concern that arose with ULP-C and that she needed to remove ULP-C from the schedule. LALD stated she called RDO about the need to fill and have back up staffing and explained that ULP-B was a new staff member; that ULP-B was in training and if she could not find staff, she would be utilizing ULP-B as the second staff member. RDO approved this request and approved for LALD to have ULP-B work the shifts on February 20th and February 21st 2024. LALD stated she attempted to fill the shifts with agency staff but no staff responded to the requests. LALD confirmed usual staffing would include for two staff to work the night shift, and if training, three staff would be scheduled. LALD explained the schedule should include one staff to orientate, one staff to train the new staff, and the second staff member; the new staff would not be counted in the staffing of the facility. LALD stated the facility had trouble with staffing and were utilizing staffing agencies to fill open shifts and that staffing was a concern. LALD indicated she was informed by RDO on February 23, 2024, during her planned leave of absence, that she needed to figure out staffing over the weekend, as corporate staff recently learned the staffing agencies utilized were not registered with the state. RDO directed LALD it was her job to fill the staffing needs of the building and provided no assistance to LALD to appropriately staff the facility. The facility's Direct Care Staffing Plan dated September 15, 2023, indicated staff have the experience, training, and competency to provide	02320		

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02320	Continued From page 23 care and services to residents as appropriate to their position. Unlicensed personnel (ULP) receive the required orientation and annual training and competency evaluation per training policy. ULP receive additional training and competency evaluation for additional nurse delegated tasks as needed and based on the residents' assessment and service plan. Under the evaluation of the direct-care staffing plan identified the following average number needed for ULPs on the Day, Evening, and Night shift as 2 ULPs. The licensee's Staffing & Scheduling policy dated January 31, 2024, noted the clinical supervisor must ensure staffing levels were adequate to address each resident's needs as identified in the service plan and contract, each resident's acuity level, as determined by the most recent assessment, the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs whether the facility has a dementia care unit, and the staff experience, training, and competency. No further information provided. Time Period for Correction: Seven (7) Days	02320		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

December 22, 2023

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Conditional License Number 412492
Health Facility Identification Number (HFID) 30601
Project Number(s) SL30601015 and HL306015963M / HL306014768C
and HL306015964M / HL306015070C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey and follow-up complaint investigation of your facility on November 15, 2023, to determine correction of orders found not corrected during the follow-up survey and follow-up complaint investigation completed on August 11, 2023, pursuant to the survey completed April 13, 2023, and complaint investigation completed March 21, 2023. Based on the follow-up survey results you were found to continue to not be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G and Minnesota Food Code, Minnesota Rules Chapter 4626.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day extension to the conditional license due to expire on **March 4, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey (SL30601015) completed on August 11, 2023, found not corrected at the time of the November 15, 2023, follow-up survey and/or subject to penalty assessment are as follows:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements - $500.00
St - 0 - 0485 - 144g.41 Subdivision 1. (13)(i)(a)and(c) - Minimum Requirements
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn
St - 0 - 1440 - 144g.62 Subd. 4 - Supervision Of Staff Providing Delegated Nurs
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - $3,000.00
St - 0 - 1650 - 144g.70 Subd. 4 (f) - Service Plan, Implementation And Revisions To
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication
St - 0 - 1880 - 144g.71 Subd. 19 - Storage Of Medications

Furthermore, at the time of the follow-up survey (SL30601015) completed on November 15, 2023, we identified the following violation(s):

St - 0 - 2350 - 144g.91 Subd. 7 - Courteous Treatment

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form

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/HRD-Appeals-Form.

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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Summit Ridge Place an extension to the conditional assisted living facility license for an additional 90 calendar days. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Summit Ridge Place is in substantial compliance.

The following conditions will remain in effect through the extended conditional license period and apply to the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. Consultant: Summit Ridge Place will continue to contract with an RN to provide consultation concerning all resident(s) to whom Summit Ridge Place provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Summit Ridge Place. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must continue to not have any affiliation with Summit Ridge Place. Summit Ridge Place will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Summit Ridge Place in an effort to help Summit Ridge Place align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Summit Ridge Place will continue to develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

c. Reports: The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Summit Ridge Place and the RN consultant about a change. Each report will continue to be electronically submitted to Carrie Euerle, Rapid Response Supervisor, State Rapid Response Team, Health Regulation Division, at carrie.euerle@state.mn.us. Carrie Euerle can be reached at 651-242-8846 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

d. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Summit Ridge Place to correct the violations cited during the follow-up survey as well as to determine the overall practice of Summit Ridge Place in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

e. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

f. **Corrective Action Plan:** Summit Ridge Place will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Summit Ridge Place is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Summit Ridge Place is in substantial compliance on the follow up survey, MDH will remove the conditions from Summit Ridge Place's assisted living facility license, and Summit Ridge Place will correct violations identified during the follow-up survey to come into substantial compliance. If MDH determines Summit Ridge Place is not in substantial compliance, MDH may take additional enforcement action against Summit Ridge Place, including placement of additional conditions, issuing an additional extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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 Carrie Euerle directly at: 651-242-8846.

Sincerely,

Maria King, RN
Division Director
Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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 *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30601015-2 On November 13, 2023, through November 15, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 13, 2023, and a revisit survey completed on August 11, 2023. At the time of the survey, there were 15 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	{0 340}		

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{0 340}	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on August 11, 2023. 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	{0 340}		

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{0 340}	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the revisit survey on November 13, 2023, through November 15, 2023, the surveyor reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews. The licensee lacked evidence to indicate the orders issued on August 11, 2023, were corrected. No further information was provided.	{0 340}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	{0 480}		

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{0 480}	Continued From page 3 a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by:	{0 485}		

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{0 485}	Continued From page 4 Based on interview and record review, the licensee failed to ensure the Assisted Living With Dementia Care contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents living in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The Resident Occupancy Agreement, page 5 of 48, section 8, titled Meal Plans, indicated the licensee offered a meal plan described in "Attachment E" that, if selected, was not included in the monthly base fee, and indicated "You are not required to select a meal plan to live in the Community." On page 33 of 48, a document titled "Attachment E Meal Plan," directed the resident to select a meal option by checking the appropriate box. The first box indicated the "3 [three] Meal- Meal Plan," which included three nutritious meals and snacks available seven days per week, and noted the resident would be charged $550 per month for this plan. The second box indicated the "2 [two] Meal- Meal Plan," which included two nutritious meals daily with snacks available seven days per week, and noted the resident would be charged $400 per month for this plan. The third box indicated "No Meal Plan," and indicated, "I do not wish to participate in a meal plan through the Community at this time." The meal plan selections lacked a	{0 485}		

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{0 485}	Continued From page 5 meal option for one meal per day. On November 15, 2023, at 1:54 p.m., assisted living director in residence (ALDIR)-C stated the contract was recently finalized by the corporate office and distributed to the facility's residents. ALDIR-C stated all of the current residents were receiving three meals daily; however, stated she could not explain why the meal plan options included two meals, three meals, or no meals, but not an option for one meal. ALDIR-C stated she had mentioned this to the regional director, but did not get a response. No further information provided.	{0 485}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of three	{0 510}		

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{0 510}	Continued From page 6 employees (licensed practical nurse (LPN)-Y, unlicensed personnel (ULP)-W), observed while providing cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 14, 2023, at 8:10 a.m., the surveyor observed LPN-Y perform a blood glucose check for R16 in her room. With gloved hands, LPN-Y wiped R16's right pointer finger with an alcohol wipe, poked it with the lancet, wiped the blood, and placed sample on the test strip. Once complete, LPN-Y removed the gloves, placed items on the bedside table, administered oral medications to R16, donned (put on) clean gloves, and administered eye drops to both eyes. At this time, LPN-Y removed the gloves, gathered her supplies, and assisted R16 to stand, brushed her hair on the way out, and walked with R16 to the dining room, where she pulled out the chair for R16 to sit down. LPN-Y then returned to the medication cart, disposed of the sharps in the sharps container, placed the glucometer on the cart, and performed hand hygiene. At this time, LPN-Y stated she was trained to perform hand hygiene before medication administration, after performing a blood glucose check, and anytime gloves were removed. On November 14, 2023, at 9:07 a.m., the	{0 510}		

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{0 510}	Continued From page 7 surveyor observed while LPN-Y and ULP-W entered R5's room, announcing they were there to help R5 to get up for the day. ULP-W donned gloves, pulled back R5's blankets, put on compression stockings and non-slip socks, and pulled pants over his feet. ULP-W asked R5 to sit up so she could change his shirt because it was "wet." ULP-W and LPN-Y assisted R5 to sit up and ULP-W removed R5's shirt and undershirt and tossed them onto the floor at the end of the bed. LPN-Y removed the gloves she was wearing and without performing hand hygiene, donned a clean pair of gloves. LPN-Y brought a medication cup to R5 and spooned pudding mixed with medications into his mouth. LPN-Y removed the gloves, and without performing hand hygiene, opened R5's door by touching the handle and the surveyor observed as she walked to the medication cart in the common area. LPN-Y tossed the gloves and medication cup into the trash and used hand sanitizer. ULP-W continued to dress R5's upper body and asked R5 to stand using the walker. ULP-W pulled up R5's pants and buttoned his shirt while he stood at the bedside, and ULP-W picked up R5's saturated brief from his bed and rolled it in her hands. ULP-W placed the brief into a clear plastic bag, removed her gloves and placed them in the bag, and tied the bag. Without performing hand hygiene, ULP-W encouraged R5 to walk beside her, while straightening R5's clothing and using her hands to straighten R5's hair. ULP-W opened R5's door, touched R5's walker to guide him through the doorway, and walked down the hallway to the dining room. ULP-W pulled out a dining room chair, touching the arms of the chair, touched the dining room table, and guided R5's hands to reach for the chair. ULP-W assisted R5 to sit in the chair and opened the door to the kitchen. ULP-W used the hand sanitizer	{0 510}		

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{0 510}	Continued From page 8 dispenser before walking into the kitchen. On November 14, 2023, at 8:17 a.m., clinical nurse supervisor (CNS)-X stated she expected staff to perform hand hygiene after a blood glucose check was performed and each time gloves were removed. On November 14, 2023, at 9:38 a.m., ULP-W stated she should have performed hand hygiene after removing the gloves and before leaving the room. ULP-W stated she often would throw soiled clothing onto the floor while she assisted a resident to dress because she didn't want to walk away from them for safety reasons. ULP-W stated she could put a bag on the floor and toss the soiled clothing or linens into the bag, rather than the floor. On November 14, 2023, at 9:45 a.m., LPN-Y stated she had been trained to perform hand hygiene when removing gloves and before leaving a resident's room, however, stated she did not do that and should have. The licensee's Infection Control Policy dated January 27, 2023, noted hand washing should be performed after changing an incontinent brief or cleaning up after someone had used the toilet. It also noted hand hygiene was to be completed after removing gloves. No further information was provided.	{0 510}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	{01380}		

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{01380}	Continued From page 9 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of seven unlicensed personnel (ULP-T). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-T was hired on September 8, 2023, to provide direct care services to residents of the facility.	{01380}		

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{01380}	Continued From page 10 ULP-T's employee record lacked documented evidence of the following required training: - recognizing physical, emotional, cognitive, and developmental needs of the resident. On November 14, 2023, at 9:07 a.m. the surveyor observed ULP-T provided cares for R5 in his room. On November 14, 2023, at 3:25 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-X were informed of the missing documentation of required training from ULP-T's employee record. LALD-B and CNS-X stated they wanted to look to see if the packet had not been filed. However, no further information was provided. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training would include recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided.	{01380}		
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	{01440}		

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{01440}	Continued From page 11 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individuals began working for the licensee for one of seven unlicensed personnel (ULP-T). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-T ULP-T was hired on September 8, 2023, to provide direct care services to residents of the facility.	{01440}		

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{01440}	Continued From page 12 ULP-T's employee record lacked evidence to document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks. On November 14, 2023, at 9:07 a.m. the surveyor observed ULP-T provided cares for R5 in his room. On November 14, 2023, at 3:25 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-X stated ULP-T did not provide any training until after the background study was cleared on September 20, 2023, and were going to see if they could find evidence of supervision in the electronic record. However, no further documentation was provided. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for residents. No further information was provided.	{01440}		
{01640} SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	{01640}		

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01640}	Continued From page 13 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all services identified in the service plan were implemented for one of one resident (R13). 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: R13 was admitted to the facility on October 27, 2023, and had diagnoses including delirium secondary to multiple medical problems and major depressive disorder. R13's assessment dated October 27, 2023,	{01640}		

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{01640}	Continued From page 14 identified as the admission assessment, indicated R13 was admitted due to poor decision making and was high risk of elopement related to being unhappy with placement at the facility. R13's November 2023 Service List included for staff to complete safety checks every two hours. R13's Resident Notes included the following: -November 3, 2023, at 9:00 p.m., indicated R13 requested to leave the facility with a male and a female visitor and stated he needed his medications. R13's power of attorney was contacted and denied permission for R13 to leave the facility. R13 and visitors became upset, and the visitors left the facility without incident. - November 4, 2023, at 1:51 a.m., indicated R13 was not in his room during a check of his room, and R13's window was noted to be broken out. An elopement emergency was activated. - November 4, 2023, at 11:45 a.m., indicated R13 was located and admitted to the hospital, and was ready to discharge back to the facility. R13's November 2023 Services Delivered documentation indicated on November 3, 2023 the last safety check completed was the scheduled 10:00 p.m. check, documented as completed at 9:24 p.m. The scheduled 12:00 a.m. safety check was not completed. Scheduled safety checks for 2:00 a.m. and 4:00 a.m. were also not documented as completed. On November 14, 2023, at 10:59 a.m., clinical nurse supervisor (CNS)-X stated a Minnesota Adult Abuse Reporting Center (MAARC) report was submitted immediately and interventions	{01640}		

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{01640}	Continued From page 15 were put in to place when R13 returned to the facility on November 4, 2023, including hourly safety checks. R13's record of Services Delivered, from November 4, 2023, through November 13, 2023, lacked the following: - November 5, 2023-no documentation of safety check at 11:00 p.m.; - November 6, 2023-no documentation of safety checks from 12:00 a.m., through 2:00 p.m., and 11:00 p.m.; - November 7, 2023-no documentation of safety checks from 12:00 a.m., through 2:00 p.m., and 11:00 p.m.; - November 8, 2023-no documentation of safety checks from 12:00 a.m., through 6:00 a.m., and 11:00 p.m.; - November 9, 2023-no documentation of safety checks from 12:00 a.m., through 6:00 a.m.; and - November 13, 2023-no documentation of safety checks from 3:00 p.m., through 10:00 p.m. R13's Service Plan (Waiver) - Addendum to Contract, signed on November 10, 2023, indicated R13 received services including dressing, bathing assistance, medication administration, behavior management related to elopement threat, and safety checks 24 times per day. On November 14, 2023, at 11:24 a.m., CNS-X reviewed the lack of documentation of the safety checks being completed hourly, and stated she was unaware that safety checks were not being implemented per the Service Plan. CNS-X stated the electronic medical record notified her of missing documentation, but was time limited and she didn't always see it.	{01640}		

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{01640}	Continued From page 16 The facility's Service Plan policy, dated August 1, 2021, indicated the licensee would implement and provide all services indicated in the service plan. No further information was provided.	{01640}		
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	{01650}		

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{01650}	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for two of six residents (R13, R15). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R13 R13's diagnoses included delirium secondary to multiple medical problems and major depressive disorder. R13's Service Plan (Waiver) - Addendum to Contract, signed on November 10, 2023, lacked the following: - a contingency plan that included the name and contact information of persons the resident wishes to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had the authority to sign for the resident in an emergency. R15 R15's diagnoses included alcoholic cirrhosis (scarring) of the liver without ascities (fluid buildup in the abdomen), diabetes, and chronic	{01650}		

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{01650}	Continued From page 18 obstructive pulmonary disease. R15's Service Plan (Waiver) - Addendum to Contract, signed on October 27, 2023, lacked the following: - a contingency plan that included the name and contact information of persons the resident wishes to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had the authority to sign for the resident in an emergency. On November 15, 2023, at 1:55 p.m., clinical nurse supervisor (CNS)-X stated she did not enter the name of the emergency contact for R13 or R15 onto the service plan, therefore, the electronic medical record did not populate the required information. CNS-X stated she was unaware that the information was missing until the emergency contact was added, and stated she had now added this information. The licensee's Service Plan policy, dated August 1, 2021, indicated the service plan would include a contingency plan that included identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency. No further information was provided.	{01650}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	{01760}		

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{01760}	Continued From page 19 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed and administered as prescribed for one of four residents (R10). 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: R10's Service Plan (Waiver) - Addendum to Contract, signed June 15, 2023, indicated R10 received services including bathing assistance, dressing, grooming, incontinence care, oxygen management, vital monitoring, safety checks, and medication management. R10's prescriber orders dated August 11, 2023, included lidocaine (used to treat itching and pain) 5% ointment, apply topically to affected area(s)	{01760}		

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{01760}	Continued From page 20 twice daily at 8:00 a.m., and 8:00 p.m. R10 was observed by the surveyors multiple times throughout the survey in the common area, working on puzzles and interacting with other residents. R10's Med (medication) Admin (administration) Summary, dated November, 2023, indicated lidocaine 5% ointment, apply to affected area daily "as needed for pain," instead of twice daily as indicated in the prescriber orders. On November 15, 2023, at 2:43 p.m., clinical nurse supervisor (CNS)-X stated she could not explain why there was a discrepancy between the prescriber orders and the Med Admin Summary, and could not locate documentation to determine if the order had changed. CNS-X stated medications should be given as prescribed and should have a current accurate order. The licensee's Medication Administration Program policy dated February 1, 2022, noted the registered nurse (RN) or designee would audit medication administration records at least monthly to ensure proper medications had been given correctly. No further information was provided.	{01760}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	{01880}		

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{01880}	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were properly stored and secured to permit access for only authorized personnel for one of fifteen residents (R15). 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: R15's diagnoses included alcoholic cirrhosis (scarring) of the liver without ascities (fluid buildup in the abdomen), diabetes, and chronic obstructive pulmonary disease. R15's Service Plan signed on October 27, 2023, by R15 and the licensee, indicated services including housekeeping, laundry, and medication administration. R15's Individualized Medication Management Plan dated November 7, 2023, noted self-administration of medications was not applicable. It also noted medication was locked in a medication cart. On November 14, 2023, at 8:40 a.m., the surveyor observed licensed practical nurse (LPN)-Y administer oral medications to R15 in his room. At this time, a Ventolin inhaler was	{01880}		

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{01880}	Continued From page 22 observed on R15's bedside table. On November 14, 2023, at 10:00 a.m., LPN-Y stated she had talked with R15 about not having the inhaler in his room, and he said other staff had given it to him to keep with him. LPN-Y was unable to locate any documentation that indicated the inhaler could be kept in his room. On November 15, 2023, at 4:15 p.m., clinical nurse supervisor (CNS)-X stated R15 should not have the inhaler in his room, and had not been assessed to self-administer medications. The licensee's Medication Administration Program policy dated February 1, 2022, noted all medications would be stored in a locked area according to pharmalogical standards for the specific medications. No further information was provided.	{01880}		
02350 SS=E	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents (R16, R5) were treated with respect, dignity, and privacy when assisted with activities of daily living. In addition, the licensee failed to ensure change of shift report was provided in a private area. This practice resulted in a level two violation (a	02350		

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02350	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R16 R16's diagnoses included diabetes and Alzheimer's Disease. R16's Service Plan (Private) - Addendum to Contract dated November 17, 2023, noted services including assistance with bathing, dressing, grooming, incontinence care, and medication administration. On November 14, 2023, at 8:00 a.m., the surveyor approached R16's room to observe licensed practical nurse (LPN)-Y perform a blood sugar check. Before entering, the resident's door was noted to be open completely, and R16 was seated on her bed, which was straight in from the door, and in front of the window that had the blinds open. Unlicensed personnel (ULP)-W was observed standing next to R16. LPN-Y asked if she and the surveyor could come in to do her blood sugar check. R16 asked if we could wait for her to get her pants up. LPN-Y stated we would come back, and closed the door. Upon returning at 8:10 a.m., R16 was fully dressed, and the blinds remained open. On November 15, 2023, at 4:39 p.m. clinical nurse supervisor (CNS)-X stated she expected	02350		

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02350	Continued From page 24 privacy be given with cares. R5 R5's diagnoses included Alzheimer's Disease, dementia with behavioral disturbance, and depression. R5's Service Plan (Private) - Addendum to Contract, signed October 31, 2023, indicated R5 received services including bathing assistance, dressing, compression stockings, grooming, behavior management, toileting, and medication management. On November 14, 2023, at 9:07 a.m., the surveyor observed while LPN-Y and ULP-W entered R5's room, announcing to R5 that they were there to help him to get up for the day. ULP-W pulled back R5's blankets, put on compression stockings and non-slip socks, and pulled pants over his feet. ULP-W and LPN-Y assisted R5 to sit up and removed R5's shirt and undershirt. While standing in front of R5, ULP-W and LPN-Y openly talked about R5's behaviors, how "good" he was being today, and how uncooperative he was at times, and discussed his fear or dislike of mirrors. While laughing, ULP-W stated she made the mistake of walking by a mirror with R5, and stated he became very upset. LPN-Y brought a medication cup to R5 and spooned pudding mixed with medications into his mouth. R5 took the medications without incident. LPN-Y stated, "Perfect, you did it without spitting at me," and LPN-Y left the room. On November 14, 2023, at 10:05 a.m., CNS-X stated she expected staff to treat residents with dignity. CHANGE OF SHIFT REPORT On November 14, 2023, at 2:27 p.m., the	02350		

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02350	Continued From page 25 surveyor observed while LPN-Y stood by the medication cart, in the common area, giving "report" to the oncoming shift, ULP-F and ULP-P. Two male residents and an unidentified female visitor were sitting in the area, within hearing distance, while LPN-Y discussed each resident, identifying them by their room number. LPN-Y stated, "[Room #'s] niece is picking them up," and "[Room #] has been weirdly incontinent," and stated needed to be changed often. LPN-Y discussed an unidentified resident having "diarrhea." On November 14, 2023, at 2:39 p.m., CNS-X stated staff were to hold change of shift report in the staff room, with the door closed for privacy. The facility's Dementia Care Philosophy policy, dated August 1, 2021, indicated the licensee's philosophy of dementia care services was to enhance the quality of life and dignity of older adults, and to create a daily routine that ensured all needs, whether physical, emotional, or spiritual were being met, by focusing on delivering care and services with purpose, compassion, and kindness to the residents they serve. The facility's Confidentiality policy, dated August 1, 2021, indicated the licensee takes confidentiality very seriously, and directed it was the employees' responsibility to stop co-workers or other staff from discussing inappropriate resident or staff information in public areas. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically delivered

September 6, 2023

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Conditional License Number 412492
Health Facility Identification Number (HFID) 30601
Project Number(s) SL30601015, HL306015963M/4768C and HL306015964M/5070C

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey and follow-up complaint investigation of your facility on August 11, 2023, to determine correction of orders found on the complaint investigation completed on March 21, 2023, and survey completed on April 13, 2023, and for the purpose of assessing compliance with state licensing statutes. Based on the follow-up complaint investigation and follow-up survey results you were found to continue to not be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G and Minnesota Food Code, Minnesota Rules Chapter 4626.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing an extension of 90-days to the conditional license due to expire on **December 5, 2023**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last complaint investigation (HL306015963M/4768C and HL306015964M/5070C) completed on March 21, 2023, found not corrected at the time of the August 11, 2023, follow-up Complaint investigation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - $500.00
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00

0485-Minimum Requirements-144g.41 Subd 1. (13) (i) (a) And (c)
0510-Infection Control Program-144g.41 Subd. 3
0650-Employee Records-144g.42 Subd. 8 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0900-Contract Required-144g.50 Subdivision 1
0910-Contract Information-144g.50 Subd. 2 (a-B)
0920-Contract Information-144g.50 Subd. 2 (c)
0930-Contract Information-144g.50 Subd. 2 (d-E; 1-4)
0980-Arbitration-144g.51
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1700-Provision Of Medication Management Services-144g.71 Subd. 2
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1820-Prescriptions-144g.71 Subd. 13
2170-Services For Residents With Dementia-144g.84

Further, in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey (SL30601015) completed on April 13, 2023, found not corrected at the time of the August 11, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0430-Uniform Checklist Disclosure Of Services-144g.40 Subd. 2
0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
1060-Emergency Relocation-144g.52 Subd. 9 - $500.00

The details of the violations noted at the time of the follow-up complaint investigation (HL306015963M/4768C and HL306015964M/5070C) and follow-up survey (SL30601015) completed on August 11, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Furthermore, at the time of the follow-up survey (SL30601015) completed on August 11, 2023, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
1390-Availability Of Contact Person To Staff-144g.62 Subdivision 1
1610-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (a-B)
1750-Delegation Of Medication Administration-144g.71 Subd. 7 - $3,000.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1880-Storage Of Medications-144g.71 Subd. 19

The details of the violation(s) noted at the time of this follow-up survey (SL30601015) are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is

substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

CONDITIONAL LICENSE ISSUED:
MDH will issue Summit Ridge Place an extension to the conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey and follow-up complaint investigation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey and follow-up complaint investigation, MDH will determine if Summit Ridge Place is in substantial compliance.

The following conditions will continue to apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. No new admissions: Summit Ridge Place will continue to not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition.

c. Consultant: Summit Ridge Place will continue to contract with an RN to provide consultation concerning all resident(s) to whom Summit Ridge Place provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Summit Ridge Place. The consultant will continue to conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. Summit Ridge Place will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Summit Ridge Place in an effort to help Summit Ridge Place align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Summit Ridge Place will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will continue to provide MDH with regular reports on a weekly basis until MDH notifies Summit Ridge Place and the RN consultant about a change. Each report will be electronically submitted to Carrie Euerle, Investigator Supervisor, State Rapid Response Team, Health Regulation Division, at carrie.euerle@state.mn.us. Carrie Euerle can be reached at 651-242-8846 (office) with questions about reports. The content of the reports will continue to include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Summit Ridge Place to correct the violations cited during the follow-up survey and follow-up complaint investigation as well as to determine the overall practice of Summit Ridge Place in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey and follow-up complaint investigation:** At the time of the follow-up survey and follow-up complaint investigation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Summit Ridge Place will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Summit Ridge Place is in substantial compliance based on the results of the follow up survey and follow-up complaint investigation. MDH will make this determination within the 90-day conditional license period. If MDH determines Summit Ridge Place is in substantial compliance on the follow up survey and follow-up complaint investigation, MDH will remove the conditions from Summit Ridge Place's assisted living facility license, and Summit Ridge Place will correct violations identified during the follow-up survey and follow-up complaint investigation to come into substantial compliance. If MDH determines Summit Ridge Place is not in substantial compliance, MDH may take additional enforcement action against Summit Ridge Place, including placement of additional conditions, issuing an additional extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. The request for hearing should be addressed to:

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Summit Ridge Place. **Please contact Carrie Euerle at 651-242-8846 on or before *September 13, 2023*, to schedule the conference call.**

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 Carrie Euerle directly at: 651-242-8846.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are issued pursuant to a survey. Determination of whether violations has been corrected requires compliance with all requirements provided at the Statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. SL30601015-1 On August 2, 2023, through August 11, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 13, 2023. At the time of the survey, there were 12 residents, all of whom received services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on August 4, 2023, issued for SL30601015-1, tag identification 1750 - Delegation of Medication Administration. On August 9, 2023, the Immediacy of correction order 1750 was removed, however non-compliance remains at a scope and severity of F.	{0 000}	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.	

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{0 000}	Continued From page 1	{0 000}	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	{0 250}		

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{0 250}	Continued From page 2 Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all 12 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 250}		

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{0 250}	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five of the application), identified "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an	{0 250}		

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{0 250}	Continued From page 4 in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements	{0 250}		

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{0 250}	Continued From page 5 related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page 6 was electronically signed by the licensee on March 29, 2023. The licensee had an Assisted Living Dementia Care license, issued on June 1, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of the resident needs; - infection control; - conducting appropriate screenings, or documentation of prior screenings, to show that staff were free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention of Standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. As a result of this follow-up survey, twenty-eight (28) correction orders were reissued, which	{0 250}		

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{0 250}	Continued From page 6 indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by:	0 340		

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0 340	Continued From page 7 Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on August 11, 2023. 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 revisit survey on August 3, 2023, through August 11, 2023, the surveyor reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews. The licensee lacked evidence to indicate the orders issued on April 13, 2023, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 480}	Continued From page 8 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 August 7, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of	{0 485}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 485}	Continued From page 9 similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's contract lacked an option for residents to opt out of payment for meals residents would not want. The contract noted on page 4 of 17, section 6. Programs and Services, under Board: "f. 1 meal per day, served in the Community dining rooms", and under Services: "q. 2 meals per day, served in the Community dining rooms". On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to the lease agreement, which was still with the legal	{0 485}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 485}	Continued From page 10 departement, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team. RDO-G stated the residents had not been provided a new contract to include the meal options. No further information provided.	{0 485}		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two employees (unlicensed personnel/ULP-H), observed while providing cares. This practice resulted in a level two violation (a	{0 510}		

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{0 510}	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 3, 2023, at 8:40 a.m., the surveyor observed ULP-H provide cares for R9 in his apartment. While R9 was seated on the edge of his bed, ULP-H donned clean gloves, and assisted R9 to put on a clean brief and pants pulled to just above his knees, shoes, and socks. ULP-H then assisted R9 to stand and hold his walker, provided perineal cares with a wipe, pulled up the brief, adjusted the tab, pulled up R9's pants, touched the walker, and assisted R9 to sit in his wheelchair, opened a cupboard to bring a washcloth, wet it in the bathroom sink, and gave it to R9 to wash his face. ULP-9 then took the washcloth, opened a drawer and removed R9's eyeglasses, unlocked the breaks on the walker, and brought R9 to the dining room for breakfast. At this time, ULP-H removed her gloves, pushed the code to enter the common bathroom, and washed her hands. On August 3, 2023, at 8:50 a.m., ULP-H stated she had been trained by her peers, and some electronic training, but had received no training by a nurse since starting. In addition, ULP-H stated she was not sure if she was trained to change gloves and perform hand hygiene after providing perineal cares. On August 4, 2023, at 8:00 a.m. via telephone	{0 510}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 510}	Continued From page 12 interview, vice president of clinical operations (VPCO)-O stated staff are expected to remove their gloves and perform hand hygiene after perineal cares are performed. The licensee's Infection Control policy dated revised January 27, 2023, noted hand washing should be performed after changing an incontinent brief or cleaning up after someone had used the toilet. It also noted hand hygiene was to be completed after removing gloves. No further information was provided.	{0 510}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	{0 650}		

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{0 650}	Continued From page 13 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for eight of eight employees (assisted living director in residency/ALDIR-C, unlicensed personnel/ULP-E, ULP-F, ULP-H, ULP-I, ULP-J, ULP-K, ULP-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ALDIR-C ALDIR-C was hired on June 15, 2022, to provide direct care services to residents of the facility. ALDIR-C's job description dated June 15, 2022, for the job of caregiver, lacked identification of staff persons providing supervision. ALDIR's employee record lacked a job description for her current duties. ULP-E ULP-E was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-E's job description dated November 10, 2022, lacked identification of staff persons providing supervision.	{0 650}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 650}	Continued From page 14 ULP-F ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-F's job description dated April 4, 2022, lacked identification of staff persons providing supervision. ULP-H ULP-H was hired on April 28, 2023, to provide direct care services to residents of the facility. ULP-H's job description dated April 29, 2023, lacked identification of staff persons providing supervision. ULP-I ULP-I was hired on April 25, 2023, to provide direct care services to residents of the facility. ULP-I's job description dated April 25, 2023, lacked identification of staff persons providing supervision. ULP-J ULP-J was hired on May 11, 2023, to provide direct care services to residents of the facility. ULP-J's employee record lacked a job description. ULP-K ULP-K was hired on June 8, 2023, to provide direct care services to residents of the facility. ULP-K's employee record lacked a job description. ULP-L	{0 650}		

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{0 650}	Continued From page 15 ULP-L was hired on June 12, 2023, to provide direct care services to residents of the facility. ULP-L's job description dated June 15, 2023, lacked identification of staff persons providing supervision. On August 3, 2023, at 11:45 a.m., ALDIR-C stated she did not have a job description for her current position. On August 3, 2023, at 3:50 p.m., ALDIR-C stated she was not aware of the issue of the missing identification of staff persons providing supervision or of the need to be included in the job description. The licensee's Employee Records policy dated March 2, 2022, noted the employee record would include a current signed job description including qualifications, responsibilities, and identification of supervisors, if any. No further information was provided.	{0 650}		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	0 660		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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0 660	Continued From page 16 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for five of six employees (unlicensed personnel (ULP)-H, ULP-I, ULP-K, ULP-L, ULP-P), and lacked documentation of a completed health history and symptom screening for six of six employees (ULP-H, ULP-I, ULP-K, ULP-L, ULP-M, ULP-P). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's facility risk assessment dated June 16, 2023, indicated the facility was a low risk. ULP-H	0 660		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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0 660	Continued From page 17 ULP-H was hired on April 28, 2023, to provide direct care services to residents of the facility. ULP-H's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and - documentation of a completed health history and symptom screening. ULP-I ULP-I was hired on April 25, 2023, to provide direct care services to residents of the facility. ULP-I's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and - documentation of a completed health history and symptom screening. ULP-K ULP-K was hired on June 8, 2023, to provide direct care services to residents of the facility. ULP-K's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and - documentation of a completed health history and symptom screening. ULP-L ULP-L was hired on June 12, 2023, to provide direct care services to residents of the facility. ULP-L's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and	0 660		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 660	Continued From page 18 - documentation of a completed health history and symptom screening. ULP-M ULP-M was hired on May 3, 2023, to provide direct care services to residents of the facility. ULP-M's employee record contained a TB Quantiferon negative test dated April 18, 2023. However, it lacked documentation of a completed health history and symptom screening. ULP-P ULP-P was hired on February 20, 2023, to provide direct care services to residents of the facility. ULP-P's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and - documentation of a completed health history and symptom screening. On August 3, 2023, at 3:39 p.m., assisted living director in residency (ALDIR)-C stated she was aware some staff had not completed the required TB testing, and told the staff it had to be completed by August 10, 2023. In addition, ALDIR-C stated she was not aware the first negative test had to come back before the employee could work with the residents. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative	0 660		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 660	Continued From page 19 IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's Tuberculosis Screening policy dated August 1, 2021, noted no staff would be permitted to work where the work involved shared air space with residents until the negative results of the first TST were read and documented or a negative blood screening was received and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	{0 680}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 680}	Continued From page 20 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 4, 2023, at 2:15 p.m., the surveyor reviewed the emergency preparedness plan with assisted living director in residency (ALDIR)-C. ALDIR-C stated some changes were made to the emergency preparedness plan since the initial survey; however, still lacked the following required content: - policy and procedure to address sewage and waste disposal; - policy and procedure to address the system to	{0 680}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 680}	Continued From page 21 track the location of on-duty staff and sheltered residents, and if on-duty staff and sheltered residents were relocated, a method to document the specific name and location of the receiving facility or other location; - a communication plan to include: - current name and contact information of the residents' physicians; and - means, in the event of evacuation, to release resident information as permitted under 45 CFR 164.51(b)(1)(ii). In addition, the licensee failed to post the emergency disaster plan prominently as required. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{0 780}	Continued From page 22 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: No further action required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{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	{0 800}		

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{0 800}	Continued From page 23 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: No further action required.	{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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	{0 810}		

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{0 810}	Continued From page 24 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: No further action required.	{0 810}		
{0 900} SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.	{0 900}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 900}	Continued From page 25 (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of its contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of its contract as required. On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to the lease agreement, which was still with the legal department, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team, so no new action	{0 900}		

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{0 900}	Continued From page 26 had been taken regarding the contract. No further information was provided.	{0 900}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include the health facility identification (HFID)	{0 910}		

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{0 910}	Continued From page 27 number. On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to the lease agreement, which was still with the legal departement, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team, so no new action had been taken regarding the contract. No further information provided.	{0 910}		
{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or	{0 920}		

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{0 920}	Continued From page 28 services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide specialized diets. On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to	{0 920}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 920}	Continued From page 29 the lease agreement, which was still with the legal departement, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team, so no new action had been taken regarding the contract. No further information was provided.	{0 920}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by:	{0 930}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{0 930}	Continued From page 30 Based on interview and record review, the licensee failed to execute a contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to the lease agreement, which was still with the legal departement, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team, so no new action had been taken regarding the contract. No further information was provided.	{0 930}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 980}	Continued From page 31	{0 980}		
{0 980} SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract's arbitration provision did not preclude, limit, or delay the ability of a resident from taking civil action. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer.	{0 980}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{0 980}	Continued From page 32 The licensee's Memory Care Agreement included on page 15, section 35 titled Mandatory and Binding Arbitration which indicated "Any dispute, claim or controversy arising out of or relating in any way to this agreement or the breach, termination, enforcement, interpretation or validity thereof, or the provisions of services or occupancy herunder {SP}, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by binding arbitration in Rochester, MN [Minnesota] before three (3) arbitrator(s). The arbitration shall be administered by Jams pursuant to its comprehensive arbitration rules and procedures (or if Jams arbitration shall not be available for any reason, then pursuant to the general arbitration rules of any nationally recognized arbitration forum). Judgment on the award entered in any arbitration hereunder may be entered in any court having jurisdiction of the parties. This clause shall no {SP} preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction". On August 2, 2023, at 8:53 a.m. via telephone call, assisted living director in residency (ALDIR)-C stated no changes had been made to the lease agreement, which was still with the legal departement, and had not been approved or provided to residents. On August 2, 2023, at 9:58 a.m., regional director of operations (RDO)-G stated the new lease agreement had been finalized internally and was currently with the legal team, so no new action had been taken regarding the contract. No further information was provided.	{0 980}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01370}	Continued From page 33	{01370}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01370}	Continued From page 34 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-H, ULP-M). 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: ULP-H ULP-H was hired on April 28, 2023, to provide direct care services to residents of the facility. ULP-H's employee record contained a transcript which listed various training. However, the record lacked documented evidence of any competency evaluation by the registered nurse (RN). ULP-M ULP-M was hired on May 3, 2023, to provide direct care services to residents of the facility. ULP-M's employee record contained a transcript which listed various training. However, the record lacked documented evidence of any competency evaluation by the RN.	{01370}		

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{01370}	Continued From page 35 On August 3, 2023, at 8:40 a.m., ULP-H was observed to provide personal cares to R9 in his apartment. On August 3, 2023, at 8:50 a.m., ULP-H stated she had been trained by other ULP-E and ULP-F, and had some computer training. However, ULP-H stated she had not received any training by a nurse. On August 3, 2023, at 4:05 p.m., assisted living director in residency (ALDIR)-C stated the competency training is be provided by herself and the unlicensed staff, with hand over hand training, not by the nurse. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted then the RN or license health professional delegated tasks, prior to the delegation, they must make certain the ULP was trained in the proper methods to perform the task and had demonstrated the ability to competently follow the procedures and perform the tasks. No further information was provided.	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse,	{01380}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01380}	Continued From page 36 and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-H, ULP-M). 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: ULP-H ULP-H was hired on April 28, 2023, to provide direct care services to residents of the facility. ULP-H's employee record contained a transcript which listed various training. However, the record lacked documented evidence of any competency evaluation by the registered nurse (RN). ULP-M ULP-M was hired on May 3, 2023, to provide direct care services to residents of the facility.	{01380}		

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{01380}	Continued From page 37 ULP-M's employee record contained a transcript which listed various training. However, the record lacked documented evidence of any competency evaluation by the RN. On August 3, 2023, at 8:40 a.m., ULP-H was observed to provide personal cares to R9 in his apartment. On August 3, 2023, at 8:50 a.m., ULP-H stated she had been trained by other ULP-E and ULP-F, and had some computer training. However, ULP-H stated she had not received any training by a nurse. On August 3, 2023, at 4:05 p.m., assisted living director in residency (ALDIR)-C stated the competency training is be provided by herself and the unlicensed staff, with hand over hand training, not by the nurse. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted then the RN or license health professional delegated tasks, prior to the delegation, they must make certain the ULP was trained in the proper methods to perform the task and had demonstrated the ability to competently follow the procedures and perform the tasks. No further information was provided.	{01380}		
01390 SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.	01390		

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01390	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure that a registered nurse (RN) was available for consultation to staff performing delegated nursing tasks and services including therapies. This had the potential to affect all 12 residents and staff 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee did not follow their own policy regarding having a nurse or health professional available to consult with direct care staff. The licensee's Availability of an RN for Staff policy dated August 1, 2021, noted the licensee would have a registered nurse available to unlicensed staff when delegated services were being provided, and noted the on call staff would respond to and provide consultation to the unlicensed staff in a timely manner. Upon entrance to the facility, on August 2, 2023, at 8:35 a.m., unlicensed personnel (ULP)-E stated assisted living director in residency (ALDIR)-C was on personal leave today, and had been instructed to not call her when she had leave. ULP-E stated she would try to find the	01390		

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01390	Continued From page 39 number for the regional staff. At 8:48 a.m., ULP-E stated she had found a number and left a voice message. At 8:50 a.m., ULP-E stated regional director of operations (RDO)-G had called back and stated she would let ALDIR-C know the surveyors were on site. On August 3, 2023, at 8:43 a.m., ULP-E approached the surveyor with a question regarding medications, and when the surveyor suggested ULP-E should ask the facility's nurse, ULP-E stated, "We don't have a nurse." When asked about calling the on call nurse, ULP-E stated, "We don't feel comfortable calling the on call nurse for a question that's not an emergency." ULP-E stated she didn't know who the nurse was that was covering from the management company, had never met her, didn't have a phone number for her, and wouldn't know how to reach her. ULP-E stated they recently had a resident with a swollen leg and an xray person came to the facility to xray the leg. The xray person wanted to speak to the nurse, and when they called the on call nurse, they were asked if it was an emergency, and were told to not call unless it was an emergency and the on call nurse hung up on them. ULP-E stated there was a posted process for when it was okay to call the on call nurse, and when it wasn't okay. On August 3, 2023, at 8:53 a.m., ALDIR-C called and the surveyor spoke with her over the phone. ALDIR-C stated she was out on personal business today, stated she has two survey binders that she would ask ULP-E to provide to us, and asked if she needed to be at the facility for us. The surveyor stated there would need to be someone here to answer our questions and get us what we needed.	01390		

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01390	Continued From page 40 On August 3, 2023, at 9:50 a.m., RDO-G entered and introduced herself to the surveyors. RDO-G stated she was fairly new to the management company. At 8:58 a.m., RDO-G stated she was hired on May 1, 2023, and was on site every other week. RDO-G stated the vice president of clinical operations (VPCO)-O's name and said she was not sure how often that person was on site. On August 3, 2023, at 8:40 a.m., the surveyor observed ULP-H provide personal cares including grooming, dressing, transfer, and ambulation assistance to R9. On August 3, 2023, at 8:50 a.m., ULP-H stated she had been trained for this job by peers and had some computer training. ULP-H stated she had received no training by a nurse since she had been hired April 28, 2023. On August 3, 2023, at 9:00 a.m., ALDIR-C stated any staff could call the provider with a change in condition, the provider group had a portal connect to the pharmacy direct to put in new orders. ALDIR-C stated only the nurse could put orders into the electronic record, and VPCO-O or the on call nurses would get the orders faxed to them to enter. In addition, ALDIR-C stated she worked with the provider group to get the updated medication lists to the pharmacy, and if the residents were out of medications, the unlicensed staff would call the pharmacy to let them know it needed to be delivered right away. ALDIR-C also stated no nurse had been on site to provide staff training since the previous RN left on June 23, 2023, and added VPCO-O was aware of the new employees being hired. On August 3, 2023. at 10:10 a.m., ALDIR-C stated a regional RN had come to do the	01390		

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01390	Continued From page 41 admission assessment for R11 on June 29, 2023, but no nurse had been on site since to do the 14-day reassessment. In addition, ALDIR-C stated the RN would be responsible for completing the service plan after the assessment was completed. However R11 was lacking a service plan, medication assessment, medication management plan, and activity evaluation / plan. In addition, ALDIR-C stated the consultant was working with RDO-G and corporate staff. She also stated hand over hand training was being completed for new employees by unlicensed personnel, no nurse training had been done for the new employees, no nurse training had been completed for the night shift to pass medications, and if a resident requested a medication at night, staff were instructed to call her and she would come in. On August 3, 2023, at 10:40 a.m., ULP-E stated the on-call nurse and emergency list had just shown up a couple days ago. There was another list before, but that was gone. On August 3, 2023, at 3:00 p.m., ALDIR-C stated the licensee provided medication management to all residents and treatment management services to some residents. On August 3, 2023, at 3:57 p.m., ALDIR-C and RDO-G stated they had asked to have a licensed practical nurse (LPN) but only have the regional nurses available after the previous RN left, and added they have not had any applicants. They now have a part time RN starting training on Monday, August 7, 2023. In addition, they stated they had only had a part time nurse posted, and were told by corporate this was based on the needs of the building.	01390		

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01390	Continued From page 42 On August 4, 2023, at 8:00 a.m., via telephone interview, VPCO-O stated she is covering for this building, and added that she oversees 26 buildings. She was the nurse that oversees and helps out, and other nurses also help out with coverage. VPCO-O stated the position had been posted as soon as they were aware the previous RN was going to leave, but only got applicants after they added an incentive bonus. VPCO-O stated she was not aware of any new employees starting since the previous RN left, and was not aware of any training being completed by an RN for the new hires. VPCO-O stated training on medication administration and delegated tasks was expected to be done by the RN, not unlicensed staff training each other. In addition, VPCO-C stated staff were to call the community nurse from 8:00 a.m. to 5:00 p.m., and the listed number on the call sheet from 5:00 p.m. to 8:00 a.m., and added "my phone is 24 hours open." On August 4, 2023, at 4:59 p.m., via telephone, ALDIR-C and RDO-G confirmed the facility had no RN hired to oversee the building but were in the process of hiring one. ALDIR-C and RDO-G confirmed VPCO-O was only available as the nurse on-call during the day time hours from 8:00 a.m. - 5:00 p.m. ALDIR-C and RDO-G indicated the licensee utilized a nurse on-call system after 5:00 p.m. and staff were aware of how to utilize this system. ALDIR-C and RDO-G stated VPCO-O was the on-call nurse for the building, but not today, as she was moving. ALDIR-C and RDO-G confirmed they became aware of an immediate order regarding medication administration competencies at 9:00 a.m. this morning. ALDIR-C and RDO-G did not know that staff had not been trained or competency tested by a nurse and indicated they had informed their corporate office of this concern, but no nurse was	01390		

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01390	Continued From page 43 available to come to the site to train. The corporate staff planned to begin training next week on Tuesday, or Wednesday, when a nurse was available to come to the site to complete trainings. ALDIR-C and RDO-G were not nurses and were unable to train staff and ALDIR-C learned today that she also was not competency tested by a nurse, so she was unable to help fill the open weekend schedule. ALDIR-C and RDO-G had already removed trained staff from the schedule as they had not completed TB testing, so only limited medication trained staff were available to fill the weekend shifts. ALDIR-C and RDO-G did not have a trained staff to work the overnight shifts but thought they could keep one staff on-call who could come and administer medication if someone needed it. However, ALDIR-C did not want to "burn her out" and was not sure how to approach this staff member on the subject. When asked about availability of an LPN or staffing agency staff, RDO-G replied, we do not use staffing agency staff in our buildings. ALDIR-C and RDO-G were not provided assistance by corporate staff or corporate nursing staff to assist with training to remove the immediacy of the correction order issued, and were provided no assistance with scheduling for the weekend to ensure trained staff were available to work the weekend shifts. On August 7, 2023, at 1:00 p.m. ALDIR-C indicated she had not yet heard from corporate staff when a nurse was available to come to the facility to train and competency test staff. ALDIR-C was told they [corporate] were working on it and they have a plan to send a nurse here to complete competency testing and training sometime this week. ALDIR-C indicated no corporate nursing staff came over the weekend or today to assist with getting staff trained and	01390		

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01390	Continued From page 44 competency tested. ALDIR-C stated she was not a nurse, and neither was RDO-G, so there was nothing they could do about helping out with training of staff. ALDIR-C said she felt bad and would have had all staff trained or retrained on Friday, immediately after learning about staff not having competency testing, but was not a nurse so she did not have the ability and had to wait for cororate staff to send an RN to the facility before anything could be done. The licensee's electronic record system showed an RN Dashboard, noted assessment reminders for R9 "7/30/23 Late", R11 "not-specified", and R12 "8/17/23". It also noted prescriber orders reminders for R9 and R12, both noting "No MD [prescriber] Order Created." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01390		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	{01440}		

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{01440}	Continued From page 45 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for two of two unlicensed personnel (ULP-H, ULP-M). 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: ULP-H and ULP-M's employee records lacked evidence to document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks. ULP-H ULP-H was hired on April 28, 2023, to provide direct care services to residents of the facility.	{01440}		

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{01440}	Continued From page 46 ULP-H's employee record lacked the above required content. ULP-M ULP-M was hired on May 3, 2023, to provide direct care services to residents of the facility. ULP-M's employee record lacked the above required content. On August 3, 2023, at 4:10 p.m., assisted living director in residency (ALDIR)-C stated no supervision of staff performing delegated tasks have been completed by anyone. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for residents. No further information was provided.	{01440}		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever	01610		

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01610	Continued From page 47 is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for two of five residents (R11, R10) as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R10 R10 was admitted for services on June 14, 2023. R10's diagnoses included failure to thrive, general weakness, metabolic encephalopathy with chronic cognitive impairment (damage to the brain), major depression, respiratory failure, chronic obstructive pulmonary disease, arthritis, moderate protein-calorie malnutrition, and	01610		

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01610	Continued From page 48 comfort cares. R10's Service Plan (Waiver) - Addendum to Contract, dated June 15, 2023, indicated R10 received services including bathing, dressing, grooming, incontinence care, meal assistance, oxygen delivery, medication administration, positioning/repositioning, monthly vital sign monitoring, safety checks, wound care, toileting, and transfer assistance. R10's Assisted Living Agreement was signed June 14, 2023. R10's record included an Assessment As Of Date intended as the initial assessment, which indicated the assessment was completed in person by the RN on June 15, 2023, or the day after being admitted, not prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, as required. R11 R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan. R11's Assisted Living Agreement was signed	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01610	Continued From page 49 June 30, 2023. R11's record lacked an initial comprehensive nursing assessment. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated they didn't currently have a registered nurse (RN) at the facility, and a RN from another facility owned by the same management company had come to do the assessment; however, it was not dated and not signed by the person that had completed it. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated an initial, comprehensive nursing assessment should have been completed for R10 and R11 prior to signing the assisted living contract or providing services. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, indicated a nursing assessment would be conducted by a RN of the physical and cognitive needs of the prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in, whichever was earlier. No further information was provided.	01610		
{01620} SS=F	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	{01620}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01620}	Continued From page 50 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 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed resident reassessment and monitoring no more than 14 calendar days after initiation of services for two of two residents (R10, R11), and within 90 calendar days from the last date of the assessment using the uniform assessment tool for one of one resident (R9) as required. 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	{01620}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01620}	Continued From page 51 portion or all of the residents). The findings include: R10 R10 was admitted for services on June 14, 2023. R10's diagnoses included failure to thrive, general weakness, metabolic encephalopathy with chronic cognitive impairment (damage to the brain), major depression, respiratory failure, chronic obstructive pulmonary disease, arthritis, moderate protein-calorie malnutrition, and comfort cares. R10's Service Plan (Waiver) - Addendum to Contract, dated June 15, 2023, indicated R10 received services including bathing, dressing, grooming, incontinence care, meal assistance, oxygen delivery, medication administration, positioning/repositioning, monthly vital sign monitoring, safety checks, wound care, toileting, and transfer assistance. R3 was admitted for services on February 18, 2022. R10's record included an Assessment As Of Date intended as the initial assessment, which indicated the assessment was completed in person by the RN on June 15, 2023. R10's record lacked a reassessment and monitoring no more than 14 calendar days after initiation of services, as required. R11 R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of	{01620}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01620}	Continued From page 52 breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan. R11's record lacked an initial comprehensive nursing assessment and lacked a reassessment and monitoring no more than 14 calendar days after initiation of services, as required. R9 R9 was admitted for services on June 1, 2022. R9's diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, retention of urine, weakness, enlarged prostate, and high blood pressure. R9's Service Plan (Private) - Addendum to Contract, dated May 26, 2023, indicated R9 received services including ambulation, bathing, dressing, grooming, meal assistance, medication set up and administration, wandering monitoring, monthly vital sign monitoring, toileting, incontinence care, and safety checks. R9's record included an Assessment As Of Date, identified as a 90 day assessment, dated May 1, 2023, or 95 days ago. R9's record lacked evidence a 90-day reassessment had been completed since then. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated they didn't currently have a registered nurse (RN) at the facility, and the 14 day assessments for R10 and R11 "didn't happen," as well as the 90 day	{01620}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01620}	Continued From page 53 assessment for R9. ALDIR-C stated they were in the process of making arrangements to have these assessments completed. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated she had deployed other nurses when needed and stated the nursing assessments should have been completed timely. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services, as needed based on changes in the needs of the resident, and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided.	{01620}		
{01640} SS=E	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	{01640}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01640}	Continued From page 54 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for one of three residents (R11). In addition, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of three residents (R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R9 R9 was admitted for services on June 1, 2022.	{01640}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01640}	Continued From page 55 R9's diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, retention of urine, weakness, enlarged prostate, and high blood pressure. R9's Service Plan (Private) - Addendum to Contract, dated May 26, 2023, indicated R9 received services including ambulation, bathing, dressing, grooming, meal assistance, medication set up and administration, wandering monitoring, monthly vital sign monitoring, toileting, incontinence care, and safety checks. R9's service plan was signed by the facility RN; however, lacked a signature or other authentication by the resident to document agreement on the services to be provided. R11 R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated they didn't currently have a registered nurse (RN) at the facility, and R11's service plan was not completed because the onsite nurse typically completed it. On August 3, 2023, at 12:00 p.m., assisted living director in residency (ALDIR)-C stated the service	{01640}		

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{01640}	Continued From page 56 plan should contain all the required content. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated she had deployed other nurses when needed and stated the service plan was part of the admission process and the nurse should have completed it. The licensee's Service Plan policy, dated August 1, 2021, indicated the service plan was the written plan between a resident or resident's designated representative and the facility about the services that would be provided to the resident, and all residents receiving assisted living services would have a service plan in place within 14 days after the date that services were first provided to the resident. No further information was provided.	{01640}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	{01650}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01650}	Continued From page 57 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for one of five residents (R10). 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: R10's diagnoses included failure to thrive. R10's Service Plan signed on June 15, 2023, lacked the following: - a contingency plan that included the name and	{01650}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01650}	Continued From page 58 contact information of persons the resident wishes to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had the authority to sign for the resident in an emergency. On August 3, 2023, at 12:00 p.m., assisted living director in residency (ALDIR)-C stated the service plan should contain all the required content. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include the schedule and method for the next planned assessment or monitoring, and a contingency plan that included identification and contact information of who the resident had authorized to sign for the resident in an emergency, and circumstances when emergency medical services were not to be summoned. No further information was provided.	{01650}		
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	{01700}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01700}	Continued From page 59 medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for one of three residents (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease	{01700}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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{01700}	Continued From page 60 (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan. R11's unsigned prescriber orders, dated July 5, 2023, included two medications to prevent heart attack/stroke, an antidepressant, three supplements, two sleep aide, mild pain reliever, and medication to decrease blood pressure. R11's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; - must be conducted face to face; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated they didn't currently have a registered nurse (RN) at the facility, and R11's medication assessment was not completed when he was admitted.	{01700}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01700}	Continued From page 61 During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated she had deployed other nurses when needed and stated the individual medication assessment was part of the initial assessment and should have been completed. The licensee's Uniform Assessment Tool policy, dated August 1, 2021, indicated the uniform assessment tool would address the following: -a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: -the reason taken; -Any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -dosage; -frequency of use; -route administered or taken; -any difficulties the resident faces in taking the medication; -whether the resident self-administers the medication; -the resident ' s preferences in how to take medication; -interventions needed n management of medications to prevent diversion of medications by the resident or others who may have access to the medications; and -provide instructions to the resident and the resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.	{01700}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01700}	Continued From page 62 No further information was provided.	{01700}		
{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	{01730}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01730}	Continued From page 63 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for one of two residents (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan.	{01730}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01730}	Continued From page 64 R11's unsigned prescriber orders, dated July 5, 2023, included two medications to prevent heart attack/stroke, an antidepressant, three supplements, two sleep aide, mild pain reliever, and medication to decrease blood pressure. R11's record lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated they didn't currently have a registered nurse (RN) at the facility, and R11's medication management plan was not completed when he was admitted. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations	{01730}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01730}	Continued From page 65 (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated she had deployed other nurses when needed and stated the medication management plan should have been completed. The licensee's Medication Management Individualized Plan policy, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medicaiton management record for each resident based on the resident's assessment that must contain the following: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; .- documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. Also included, the medication management record would be current and updated when there were any changes.	{01730}		

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{01730}	Continued From page 66 No further information was provided.	{01730}		
01750 SS=I	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 interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency to a registered nurse (RN) for administering medications for one of one ULP (ULP-J). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01750		

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01750	Continued From page 67 This resulted in an immediate order on August 4, 2023, at approximately 9:00 a.m. The findings include: ULP-J was hired on May 11, 2023, to provide direct care services to residents of the assisted living with dementia care facility. On August 3, 2023, at 8:43 a.m., ULP-E stated she had to train ULP-J, since ULP-J was working the evening shift and had not been trained to give medications. ULP-E stated she was told to come in and train ULP-J, so she could give medications. On August 3, 2023, at 10:10 a.m. assisted living director in residency (ALDIR)-C stated they do not have a nurse here, and stated the new staff have not been trained to administer medications. ALDIR-C stated during the night shift if a resident needed a medication, she would come in to administer, as she lived close by. ALDIR-C also stated the ULP were provided hand-over-hand training by the lead ULP staff. On August 4, 2023, at 6:10 a.m., ULP-J stated she had counted medications with ULP-E. ULP-E came back in later that shift at 8:00 p.m. to train ULP-J on medication administration, and ULP-J independently administered the medications the following day. ULP-J stated she has received no training from a nurse. R5's Med (Medication) Admin (Administration) Summary - Month, dated July 2023, included ULP-J's initials on July 1, 2023, and July 2, 2023, to indicate ULP-J had administered the following medications: - July 1, 2023 - 2:00 p.m. divalproex SPR 125	01750		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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01750	Continued From page 68 milligram (mg) (used to treat seizures or mood condition); - July 1, 2023 - 2:00 p.m. furosemide 20 mg (used to decrease edema); - July 2, 2023 - 8:00 a.m. aspirin EC 81 mg (mild pain reliever); - July 2, 2023 - 8:00 a.m. divalproex SPR 125 mg; - July 2, 2023 - 8:00 a.m. furosemide 40 mg; - July 2, 2023 - 8:00 a.m. sertraline 100 mg (antidepressant); - July 2, 2023 - 2:00 p.m. divalproex SPR 125 mg; and - July 2, 2023 - 2:00 p.m. furosemide 20 mg. R10's Med Admin Summary - Month dated July 2023 included ULP-J's initials on July 1, 2023, and July 2, 2023, to indicate ULP-J had administered the following medications: - July 1, 2023 - 7:00 a.m. pantoprazole 40 mg (decrease stomach acid); - July 1, 2023 - 8:00 a.m. dilaudid 2 mg (pain reliever); - July 1, 2023 - 8:00 a.m. duloxetine 60 mg (antidepressant); - July 1, 2023 - 8:00 a.m. fluticasone 50 microgram (mcg) (to treat allergies); - July 1, 2023 - 8:00 a.m. lidocaine 5% ointment (pain reliever); - July 1, 2023 - 8:00 a.m. Miralax 17 grams (g) (to treat constipation); - July 1, 2023 - 8:00 a.m. prednisone 7.5 mg (to treat inflammation); - July 1, 2023 - 12:00 p.m. dilaudid 2 mg; - July 2, 2023 - 7:00 a.m. pantoprazole 40 mg (decrease stomach acid); - July 2, 2023 - 8:00 a.m. dilaudid 2 mg (pain reliever); - July 2, 2023 - 8:00 a.m. duloxetine 60 mg (antidepressant);	01750		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 69 - July 2, 2023 - 8:00 a.m. fluticasone 50 microgram (mcg) (to treat allergies); - July 2, 2023 - 8:00 a.m. lidocaine 5% ointment (pain reliever); - July 2, 2023 - 8:00 a.m. Miralax 17 grams (g) (to treat constipation); - July 2, 2023 - 8:00 a.m. prednisone 7.5 mg (to treat inflammation); and - July 2, 2023 - 12:00 p.m. dilaudid 2 mg. R11's Med Admin Summary - Month dated July 2023 included ULP-J's initials on July 1, 2023, and July 2, 2023, to indicate ULP-J had administered the following medications: - July 1, 2023 - 10:00 a.m. bupropion 200 mg (antidepressant); - July 1, 2023 - 10:00 a.m. Cozaar 50 mg (to treat high blood pressure); - July 1, 2023 - 10:00 a.m. Eliquis 5 mg (to prevent blood clots); - July 1, 2023 - 10:00 a.m. fluticasone/salmeterol aerosol 250/50 (to treat asthma); - July 1, 2023 - 10:00 a.m. pantoprazole 40 mg; - July 1, 2023 - 10:00 a.m. spironolactone 12.5 mg (to treat high blood pressure); - July 1, 2023 - 11:00 a.m. multivitamin 1 tablet (supplement); - July 1, 2023 - 11:00 a.m. toprol XL 25 mg (to treat high blood pressure); - July 1, 2023 - 11:00 a.m. Vitamin B1 100 mg (supplement); - July 2, 2023 - 10:00 a.m. bupropion 200 mg (antidepressant); - July 2, 2023 - 10:00 a.m. Cozaar 50 mg (to treat high blood pressure); - July 2, 2023 - 10:00 a.m. Eliquis 5 mg (to prevent blood clots); - July 2, 2023 - 10:00 a.m. fluticasone/salmeterol aerosol 250/50 (to treat asthma); - July 2, 2023 - 10:00 a.m. pantoprazole 40 mg;	01750		

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01750	Continued From page 70 - July 2, 2023 - 10:00 a.m. spironolactone 12.5 mg (to treat high blood pressure); - July 2, 2023 - 11:00 a.m. multivitamin 1 tablet (supplement); - July 2, 2023 - 11:00 a.m. toprol XL 25 mg (to treat high blood pressure); and - July 2, 2023 - 11:00 a.m. Vitamin B1 100 mg (supplement). Review of the facility's Block Schedule (Week 1) indicated ULP-J was scheduled and assigned to administer medications on July 1, 2023, for the 6:30 a.m. to 2:30 p.m. shift. Review of the facility's Block Schedule (Week 2) indicated ULP-J was scheduled and assigned to administer medications on July 2, 2023, for the 6:30 a.m. to 2:30 p.m. shift. ULP-J's record lacked evidence the RN instructed the ULP in the proper methods to administer the medications, and ensured the ULP demonstrated the ability to competently follow the procedures. On August 4, 2023, at 8:00 a.m., regional clinical nurse supervisor (CNS)-O stated she was the nurse covering the facility and also delegated other nurses for coverage; however, she stated she has never been in this building personally. CNS-O stated training of the ULP should be completed by an RN for medications and delegated tasks per policy. CNS-O also stated she was not aware of any new employees hired since the last RN left the end of June. The licensee's 5.08 Instructor & Competency Evaluation Requirements dated August 1, 2021, indicated training and competency evaluations of unlicensed personnel providing assisted living services must be completed by a RN, or another	01750		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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01750	Continued From page 71 instructor may provide training in conjunction with the RN. No further information was provided. Immediacy was removed on August 9, 2023 and reviewed by evaluation supervisor, however noncompliance remains at a scope and severity of F.	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of four residents (R10). 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	01760		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01760	Continued From page 72 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: R10's diagnoses included failure to thrive and chronic obstructive pulmonary disease (COPD). R10's Service Plan, signed June 15, 2023, noted services including assistance with positioning, toileting, transferring, and medication administration. R10's prescriber orders, dated June 19, 2023, included: - diclofenac 1% topical gel,, apply 2 grams to wrist / hand area two times daily; - hydromorphone 2 milligram (mg) tablets, 1 tablet three times daily; - hydromorphone 2 mg tablets, 1 tablet four times daily; and - tamsulosin 0.4 mg, 1 capsule daily. R10's Med (Medication) Admin (Administration) Summary - Month, dated August 2023 included: - Dilaudid (brand name for hydromorphone) 2 mg tablets, give one tablet three times daily at 8:00 a.m., 12:00 p.m., and 8:00 p.m.; and - tamsulosin 0.4 mg, take two capsules in the evening at 8:00 p.m. R10's Med Admin Summary - Month, dated August 2023 did not include diclofenac gel. On August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated the orders should match the medication administration	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 73 record. The licensee's Medication Administration Program policy dated February 1, 2022, noted the registered nurse (RN) or designee would audit medication administration records at least monthly to ensure proper medications had been given correctly. No further information was provided.	01760		
{01820} SS=E	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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of three residents (R10, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	{01820}		

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	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

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{01820}	Continued From page 74 On August 3, 2023, at 3:00 p.m., assisted living director in residency (ALDIR)-C stated the licensee provided medication management services to their residents. R10 R10's diagnoses included chronic obstructive pulmonary disease (COPD) and anxiety. R10's Service Plan dated June 15, 2023, noted services including assistance with bathing, dressing, grooming, positioning, oxygen and medication administration. R10's prescriber orders dated June 15, 2023, included a note to discontinue liquid lorazepam, and an order for lorazepam tablet. They also included an order for Ensure supplement. However, the orders lacked a written or electronic signature by the prescriber. R10's August 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R11 R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan.	{01820}		

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{01820}	Continued From page 75 R11's prescriber orders, dated July 5, 2023, included two medications to prevent heart attack/stroke, an antidepressant, three supplements, two sleep aide, mild pain reliever, and medication to decrease blood pressure. The prescriber orders lacked a written or electronic signature by the prescriber. R11's Med (Medication) Admin (Administration) Summary, dated August 2023, listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On August 3, 2023, at 10:08 a.m., assisted living director in residency (ALDIR)-C stated R11 had an annual physical at the Veteran's Administration on July 5, 2023, and the above medication list was provided when he returned. ALDIR-C stated the medication list was not signed by the prescriber. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated she had deployed other nurses when needed and stated, as part of the admission process, the facility should have signed orders for the medications they are administering. The licensee's Medication Administration Program policy dated February 1, 2022, noted the licensee would maintain a current list of medications in conjunction with the signed prescriber orders. No further information was provided.	{01820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01880	Continued From page 76	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one medication cart. 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: On August 5, 2023, at 6:10 a.m., the surveyor observed unlicensed personnel (ULP)-M open the medication cart with keys and ULP-F. ULP-M opened the narcotic locked box with the keys and counted the narcotics with ULP-F. ULP-M stated she had been trained to administer medications by assisted living director in residency (ALDIR)-C, and had been told yesterday that she could not pass medications until she had received training by the registered nurse (RN). On August 4, 2023, at 8:00 a.m., vice president of	01880		

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01880	Continued From page 77 clinical operations (VPCO)-O stated it was not their policy for ULP staff to train peers on medication administration, and said medication administration and delegated tasks training should be completed by the RN. On August 6, 2023, at 6:05 a.m., ULP-J and ULP-K stated they worked the overnight shift, and were instructed to call ULP-E during their shift if a resident required as needed medications, because they had not been trained by the RN and could not administer medications until that happened. ULP-J and ULP-K stated they were told they would be trained for administration of medications, but didn't know when. At 6:31 a.m., the surveyor observed ULP-K reach into her pocket for keys, and used the keys to open the medication cart and then used the keys to unlock the narcotic locked box. ULP-K counted the narcotics with ULP-F. On August 6, 2023, at 6:34 a.m., ULP-J stated the keys for the medication cart were on the key ring with other master keys that they carried during the overnight shift. The licensee's Medication Storage policy, dated August 1, 2021, included, "When medications are managed and stored by Cornerstone Management Services, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information was provided.	01880		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}		

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{02040}	Continued From page 78 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		
{02170} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	{02170}		

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{02170}	Continued From page 79 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for one of three residents (R11) who resided in an assisted living with dementia care 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee had an Assisted Living with	{02170}		

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{02170}	Continued From page 80 Dementia Care (ALFDC) license effective June 1, 2023. R11 R11 was admitted for services on June 29, 2023. R11's diagnoses included coronary artery disease (major blood vessels supplying the heart are narrowed causing chest pain and shortness of breath), left hemiparesis (weakness on one side), chronic obstructive pulmonary disease (obstruction of airflow through the lungs), alcohol dependence, congestive heart failure, stroke, high blood pressure, and major depression. R11's record lacked a service plan. R11's record lacked an initial comprehensive nursing assessment and lacked a reassessment and monitoring no more than 14 calendar days after initiation of services. R11's record lacked an evaluation for activities that addressed the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R11's record lacked an individualized activity plan based on the activity evaluation that reflected R11's activity preferences and needs, as required. During a telephone interview on August 4, 2023, at 8:00 a.m., vice president of clinical operations	{02170}		

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{02170}	Continued From page 81 (VPCO)-O stated she was the nurse covering this facility, however, stated she had never been to the facility. VPCO-O stated the life enrichment staff typically completed the evaluation for activities and created an individualized activity plan; however, she didn't know if this facility had life enrichment staff or if the evaluations and activity plans were being completed. The licensee's Activity Programming policy, dated August 1, 2021, lacked information on the activity evaluation or individualized activity plan. No further information was provided.	{02170}		

DEPARTMENT OF HEALTH

Type: Follow-Up
Date: *08/07/23*
Time: 11:40:03
Report: 1037231193

Food and Beverage Establishment Inspection Report

Location:

Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:

ID #: 0037540
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203161604
ID #:

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

The following orders previously issued on 04/10/23 have NOT been corrected.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

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

PREVIOUSLY ISSUED 12/18/19. AT TIME OF INSPECTION, DISHWASHER WAS READING A CHLORINE CONCENTRATION OF 0 PPM. 8/7/23 DISHWASHER WAS READING A CHLORINE CONCENTRATION OF 10PPM. DISCONTINUE USING THE DISHWASHER UNTIL UNIT IS MAINTAINING 50-100PPM CHLORINE.

Issued on: 04/10/23 *Comply By: 04/10/23*

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

INTERIOR OF ICE MAKER HAS MOLD. CLEAN INTERIOR OF ICE MAKER AND MAINTAIN CLEAN. 8/7/23 NO CHANGE. CLEAN THE INTERIOR OF THE ICE MAKER TO ELIMINATE MOLD.

Issued on: 04/10/23 *Comply By: 04/17/23*

Type: Follow-Up
Date: *08/07/23*
Time: 11:40:03
Report: 1037231193
Summit Ridge Place

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 10 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

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

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

I acknowledge receipt of the inspection report number 1037231193 of 08/07/23.

Certified Food Protection Manager: TAMERA GLOVER

Certification Number: 117446 Expires: 01/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Electronically Delivered

May 3, 2023

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Project Number(s) SL30601015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

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

The total amount you are assessed is $6,000.00. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30601015-0 On April 10, 2023, through April 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 13 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on April 11, 2023, issued for SL30601015 tag identification 0470. On April 11, 2023, the immediacy of correction order 0470 was removed, however non-compliance remained at a scope and level of G. An immediate correction order was identified on April 11, 2023, issued for SL30601015, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Continued From page 1 On April 12, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 2 Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 3 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 April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated she was familiar with the current assisted living regulations. The licensee's Provisional Assisted Living Licensure Information and Application, section titled Official Verification of Owner or Authorized Agent, (page 17 and 18 of the application) identified, I certify I have read and understand the following: [a mark was placed in the space before each of the following]: - Assisted Living Licensure statutes in Minn. [Minnesota] Stat. [Statute] chpt. [chapter] 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted	0 250		

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0 250	Continued From page 4 to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH [Minnesota Department of Health] issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.	0 250		

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0 250	Continued From page 5 - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 18 was electronically signed by the licensee on April 7, 2022. The licensee had an assisted living dementia care license issued on June 1, 2022, with an expiration date of May 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of the resident needs; (3) infection control; (4) medication management; and (5) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0470, 0480, 0485, 0510, 0530, 0540, 0580, 0640, 0650, 0680, 0730, 0780, 0790, 0800, 0810, 0900, 0910, 0920, 0930, 0980, 1370, 1380, 1440, 1470, 1620, 1640, 1650, 1700, 1730, 1790, 1820, 2040, 2170, 2180, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 250		

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0 250	Continued From page 6 (21) days	0 250		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure sufficient staffing to meet the needs of one of one resident (R4), who required two person transfers with a	0 470	An immediate correction order was identified on April 11, 2023, issued for SL30601015 tag identification 0470 at 9:36 a.m.	4/11/23

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0 470	Continued From page 7 mechanical lift. 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: The licensee lacked sufficient staffing to meet R4's needs on a 24 hour basis as required by R4's assessment and service plan. During the entrance conference on April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated two unlicensed personnel (ULP) were scheduled from 6:30 a.m. to 2:30 p.m., two ULP were scheduled from 2:30 p.m. to 10:30 p.m., and one ULP was scheduled from 10:30 p.m. to 6:30 a.m. In addition, CNS-A stated one resident (R4) was a two person assist with a mechanical lift. Assisted living director in residency (ALDIR)-C stated if staff required the assistance of a second staff on the night shift, they would call her to come in. R4's diagnoses included Parkinson's disease and Alzheimer's disease. R4's unsigned service plan dated March 23, 2023, noted resident was non-ambulatory and was unable to exit the building without total assistance, and required safety checks every two hours for falls.	0 470	On April 11, 2023, the immediacy of correction order 0470 was removed at 4:37 p.m.	

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0 470	Continued From page 8 R4's Global Deterioration Scale dated March 10, 2023, noted R4 had a very severe cognitive decline, to include all verbal abilities lost, may have spontaneous verbalizations, frequently no speech at all, only grunting. R4's comprehensive assessment dated March 10, 2023, noted the resident was unable to make needs understood, and staff were to anticipate needs and ask yes / no questions. It noted R4 was non-ambulatory and preferred assist of two staff with a mechanical lift, and was unable to exit the building without total physical assistance. It noted R4 was not oriented and was not capable of independent decision making. The assessment noted the resident preferred night time care to include safety checks and comfort checks. In addition, it noted the resident was incontinent of bladder and bowels, and utilized incontinence products. The assessment also noted the resident transferred with a mechanical lift/hoyer, was unable to bear weight, and transferred with the assistance of two staff and the hoyer lift, and assist of two for turning or repositioning in bed. It noted R4 did not participate in the turning and repositioning. The resident's flowsheet for March 2023, noted two trained staff must be present during hoyer lift transfers, and staff would check the incontinence brief and change if soiled or wet every two hours. On April 10, 2023, at 3:55 p.m., the evaluator knocked at R4's room door, asked if it was ok to come in, and R4 stated yes. R4 was observed in a hospital bed on his back, with bilateral quarter bedrails in the raised position. Resident was asked if he ever needed help from staff at night, or to get up to use the toilet during the night. However, R4 said he has only been there a	0 470		

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0 470	Continued From page 9 couple months, and asked who the evaluator was numerous times after being introduced upon entering the room. R4 was unable to participate in the interview. On April 10, 2023, at 3:07 p.m., ALDIR-C stated if staff needed to transfer R4 at night, they would call her to come in to help, as she only lives about seven minutes away, and added this has not happened since she has been here. ALDIR-C stated she has been here in training for the ALDIR position since November, but worked on the floor prior to that. On April 11, 2023, at 6:20 a.m., ULP-D stated she always works the night shift. ULP-D stated R4 is turned and repositioned as well as gets his incontinent brief changed on the night shift. He also gets as needed (prn) medication for anxiety or pain. He was up most of the night yelling, so ULP-D spent time in his room sitting with him. ULP-D stated R4 requires two staff to turn and reposition, and to transfer with the hoyer lift. At night to reposition, she uses a "soaker pad" under the resident to pull him up in the bed. ULP-D stated R4 asked to get up this morning, but she was unable to get him up on her own because the hoyer lift requires two staff. In an emergency, ULP-D stated she would probably call a coworker to help or the police. She stated she was not instructed to call ALDIR-C to help transfer the resident on the night shift. ULP-D stated there has been only one person working the night shift for a long time, and was unable to recall when it changed from two staff. ULP-D stated it changed when the census went down, and staff were told by ALDIR-C the night shift was going down to one staff. On April 11, 2023, at 8:11 a.m., CNS-A stated R4	0 470		

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0 470	Continued From page 10 is to be turned and positioned every two hours, was non-ambulatory, and required total assistance of staff to exit the building in an emergency. CNS-A stated the assessment notes two staff to turn and reposition, but it could be done with one staff, as the resident is "little". CNS-A stated during the night, staff could call ALDIR-C or the medics for assistance, or even hospice, but in an emergency they would probably call the medics. At 8:23 a.m., ALDIR-C joined the interview. Both stated the current staffing plan noted two staff for the night shift. ALDIR-C stated this probably changed around Christmas time, when a resident with behaviors discharged, and they were able to decrease the staffing. ALDIR-C and CNS-A stated they should have updated the staffing plan at that time. ALDIR-C stated the schedule for April 9, 2023, included two staff, as they had split the shift. In addition, ALDIR-C stated if she was working the night shift and needed help, she would call 911 or hospice for assistance. The licensee's Direct-Care Staffing Plan dated November 18, 2022, noted a census of 14, one resident with a two person assist and/or mechanical lifts, and identified two ULPs for the night shift. It also noted a minimum of two direct-care staff would be scheduled and available to assist at all times whenever a resident required the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 24, 2023, noted the number of unlicensed direct care staff typically scheduled for the night shift was two.	0 470		

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0 470	Continued From page 11 The licensee's posted schedule for April 2, 2023 through April 15, 2023, noted one ULP assigned to the night shift from 10:30 p.m. to 6:30 a.m., except for April 9, 2023, which noted two ULP names. The licensee's Acceptance of Residents policy dated August 1, 2021, noted the licensee would only accept a resident if they had staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in each resident's contract. The licensee's Staffing & Scheduling policy dated revised March 8, 2023, noted the clinical supervisor must ensure staffing levels were adequate to address each resident's needs as identified in the service plan and contract, each resident's acuity level, as determined by the most recent assessment, the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs whether the facility has a dementia care unit, and the staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyor's on-site observation, and review by evaluation supervisor on April 11, 2022, however non-compliance remains at a scope and level of level three, isolated (G).	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 12 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 485		

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0 485	Continued From page 13 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's contract lacked an option for residents to opt out of payment for meals residents would not want. During the entrance conference on April 10, 2023, at approximately 10:30 a.m., clinical nurse	0 485		

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0 485	Continued From page 14 supervisor (CNS)-A and assisted living director in residency (ALDIR)-C stated the licensee provided three meals per day to the residents. R1's Memory Care Agreement signed by R1 on June 23, 2022, noted on page 4 of 17, section 6. Programs and Services, under Board: "f. 1 meal per day, served in the Community dining rooms", and under Services: "q. 2 meals per day, served in the Community dining rooms". R2's Memory Care Agreement signed by R2's daughter on June 21, 2022, noted on page 4 of 17, section 6. Programs and Services, under Board: "f. 1 meal per day, served in the Community dining rooms", and under Services: "q. 2 meals per day, served in the Community dining rooms". On April 12, 2023, at 10:40 a.m., ALDIR-C stated the meals were all inclusive, but discussed with the family on admission. In addition, ALDIR-C stated the contracts for all residents currently lacked the option for resident to opt out of meals. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 15 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of two employees (unlicensed personnel/ULP-E), observed while providing cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 11, 2023, at 10:05 a.m., the surveyor observed ULP-E and ULP-F provide cares for R4 in his bed. With gloved hands, ULP-E lowered the incontinent brief, and provided perineal care with her right hand,as R4 had been incontinent of bowel. ULP-E cleaned the area with a wipe, removed the old brief, placed a new brief behind R4's back side and tucked it under, and adjusted the shirt. At this time, ULP-E removed the glove from her right hand and donned a clean glove without performing hand hygiene, and placed	0 510		

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0 510	Continued From page 16 Aquaphor cream on the residents back just above the brief line. ULP-E then turned R4 on his back, placed the clean incontinent brief, boosted the resident up in bed, adjusted the clothing, and placed a pillow between the resident's knees, raised the bedrail on the right side of the bed, pulled up the covers, and returned the wipes to a drawer. At this time, ULP-E removed her gloves, and raised the head of the bed with the remote, turned off the radio at the bedside, and went to the bathroom to wash her hands. After exiting the resident's room, ULP-A stated she had probably been taught to remove the gloves and perform hand hygiene after performing a dirty task, and to perform hand hygiene any time the gloves were removed, but she forgot. On April 11, 2023, at 4:43 p.m., clinical nurse supervisor (CNS)-A stated she would expect staff to perform hand hygiene between a dirty and clean task, and each time gloves were removed. The licensee's Infection Control policy dated revised January 27, 2023, noted hand washing should be performed after changing an incontinent brief or cleaning up after someone had used the toilet. It also noted hand hygiene was to be completed after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other	0 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 530	Continued From page 17 guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to consider resident council recommendations and grievances. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 10, 2023, at approximately 10:30 a.m., assisted living director in residency (ALDIR)-C stated the licensee currently had no resident council meetings, had not made an attempt to offer a meeting, and therefore had not developed a process to consider resident council	0 530		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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0 530	Continued From page 18 recommendations. The licensee's Resident and Family Councils policy dated August 1, 2021, noted the licensee would provide residents and families the opportunity, space and privacy for meetings, and noted the facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to consider	0 540		

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0 540	Continued From page 19 family council recommendations and grievances. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 10, 2023, at approximately 10:30 a.m., assisted living director in residency (ALDIR)-C stated the licensee currently had no family council meetings, had not made an attempt to offer a meeting, and therefore had not developed a process to consider family council recommendations. The licensee's Resident and Family Councils policy dated August 1, 2021, noted the licensee would provide residents and families the opportunity, space and privacy for meetings, and noted the facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580		

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0 580	Continued From page 20 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2023, at 10:32 a.m. assisted living director in residency (ALDIR)-C stated the licensee had not had any quality management meetings, and this was being developed. The licensee's Quality Management Project	0 580		

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0 580	Continued From page 21 policy, dated August 1, 2021, noted the licensee would have at least one documented quality management project in place at all times, and would retain the records for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 640		

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0 640	Continued From page 22 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 failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During the tour of the facility, on April 10, 2023, at approximately 10:00 a.m., the surveyor did not observed the required 911 posting. On April 10, 2023, at 3:07 p.m., assisted living director in residency (ALDIR)-C stated the non-emergency contact number was posted in the common area, but not the 911 emergency number. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, noted the licensee would post the 911 emergency number in common areas and near telephones provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 23 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of three employees (unlicensed personnel/ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 650		

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0 650	Continued From page 24 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-E's job description signed on November 10, 2022, by ULP-E, lacked identification of staff persons providing supervision. ULP-F ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-F's job description signed on April 4, 2022, by ULP-F, lacked identification of staff persons providing supervision. On April 13, 2023, at approximately 9:05 a.m., clinical nurse supervisor (CNS)-A said the job descriptions lacked the required content to identify the staff persons providing supervision. The licensee's Employee Records policy dated March 2, 2022, noted the employee record would include a current signed job description including qualifications, responsibilities, and identification of supervisors, if any. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 25 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. 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	0 680		

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0 680	Continued From page 26 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2023, at 11:05 a.m., the surveyor reviewed the emergency preparedness plan with assisted living director in residency (ALDIR)-C. ALDIR-C said the licensee lacked a customized emergency preparedness plan to include: - hazard vulnerability assessment; - identification of at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - policy and procedure to address sewage and waste disposal; - policy and procedure to address the system to track the location of on-duty staff and sheltered residents, and if on-duty staff and sheltered residents were relocated, a method to document the specific name and location of the receiving facility or other location; - policy and procedure to address the safe evacuation from the facility; - a communication plan to include: - current name and contact information of the residents' physicians - primary and alternate means of communicating with the facility staff and Federal, State, tribal, regional and local emergency management agencies; - means, in the event of evacuation, to release resident information as permitted under 45 CFR 164.51(b)(1)(ii); - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	0 680		

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0 680	Continued From page 27 designee; - method for sharing information from the emergency plan, that the facility had determined appropriate, with residents and their families representatives; - documentation of the plan being reviewed and updated annually; - EP training and testing program. In addition, the licensee failed to post the emergency disaster plan prominently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	0 730		

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0 730	Continued From page 28 (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged 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 an isolated scope (when one or a	0 730		

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0 730	Continued From page 29 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the facility on December 9, 2022, and discharged to veterans affairs (VA) on March 2, 2023. R3's diagnoses included Parkinson's disease, diabetes mellitus type II, hypertension, and Alzheimer's disease. R3's unsigned service plan dated February 10, 2023, noted services including assistance with bathing, incontinence care, and medication administration. R3's record lacked a discharge summary to include: - a summary of the resident's stay including diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On April 12, 2023, at 9:08 a.m., clinical nurse supervisor (CNS)-A stated a discharge summary should have been done, but was not done. CNS-A stated it had been missed. The licensee's undated Contract Termination policy noted at the time of discharge, the licensee would provide a written discharge summary including a summary of the resident's stay including diagnoses, course of illnesses,	0 730		

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0 730	Continued From page 30 allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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
0 780	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain and interconnect smoke alarms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During the facility tour on April 10, 2023, at approximately 1:15 p.m. with the Assisted Living Director in training (ALDIR)-C, it was observed that the smoke alam in room 19 was out of date. The Assisted Living Director in training (ALDIR)-C verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 32 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with the MN State Fire Code. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on April 10, 2023, at approximately 11:40 a.m. with the Assisted Living Director in training (ALDIR)-C, it was observed that the fire extinguishers monthly checks were not completed. Assisted Living Director in training (ALDIR)-C verbally confirmed survey staff observations during the facility tour.	0 790		

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0 790	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 790		
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 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 10, 2023, between 11:30 a.m. and 1:30 p.m., survey staff toured with the Assisted Living Director in training (ALDIR)-C . During the facility tour, survey staff observed the following:	0 800		

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0 800	Continued From page 34 1. Door closers have been removed from the mechanical room, furnance room, fire panel room and laundry room. 2. Door hardware has been removed from the laundry room door leaving a hole above the new hardware. 3. 4 out of the 6 emergency lights that were tested did not function. 4. Room 2 had a rubber door wedge propping the door open. 5. A 32 gallon rubbermaid container filled with combustible materials and cigarette butts were found next to the vinyl sided facility acrossed from a sign that said "no smoking within 20 feet from buiding." At 11:15 am Survey staff witnessed a resident smoking at a table less than 4 feet from the building. 6. Upon entry of the building it was observed that there was multiple cigarette butts disgarded in front of the building and during the tour it was observed by survey staff multiple cigarette butts were in leaves along the sidewalks and flower pots filled with potting soil. 7. The emergency egress to the courtyard was obstructed by snow. Assisted Living Director in training (ALDIR)-C verbally confirmed survey staff observations during the facility tour. No further information was provided. 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	0 810		

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0 810	Continued From page 35 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to	0 810		

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0 810	Continued From page 36 conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On April 10, 2023, between 11:30 a.m. and 1:30 p.m., survey staff toured the facility with the Assisted Living Director in training (ALDIR)-C . During the documenation review, it was revealed the facility failed to provide required documentation. Documents that were provied were reviewed by survey staff on April 10, 2023, between 11:30 a.m. and 1:30 p.m, 1. The licensee failed to provide unique or unusual resident needs for movement or evacuation. 2. The licensee failed to provide employee training logs for fire safety and evacuation. 3. The licensee failed to provide the required employee training frequency. 4. The licensee failed to provide annual fire safety and evacuation training for residents. 5. Training documentation were requested by survey staff but were not provided. Assisted Living Director in training (ALDIR)-C verbally confirmed survey staff observations during the documentation review.	0 810		

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0 810	Continued From page 37 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of its contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of its contract as required. On April 12, 2023, at approximately 10:45 a.m., assisted living director in residency (ALDIR)-C stated she was not sure if an unsigned copy of the contract had been provided to OOLTC, and would check with the corporate office. However, no updates were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name	0 910		

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0 910	Continued From page 39 and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1, R2). This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include the following required content: - health facility identification (HFID) number. R1 R1's diagnoses included hypertension and depression. R1's service plan signed by R1 on October 25,	0 910		

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0 910	Continued From page 40 2022, noted R1 received services including assistance with bathing, grooming, dressing, and medication administration. R1's Memory Care Agreement signed by R1 on June 23, 2022, lacked the above required content. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's unsigned service plan dated March 12, 2023, noted R2 was mobile with a wheelchair, and received services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's Memory Care Agreement signed by R2's daughter on June 21, 2022, lacked the above required content. On April 12, 2023, at approximately 10:45 a.m., assisted living director in residency (ALDIR)-C stated none of the contracts contained the HFID number. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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0 920	Continued From page 41	0 920		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1, R2). This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 920		

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0 920	Continued From page 42 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to provide a contract to include: - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide specialized diets. R1 R1's diagnoses included hypertension and depression. R1's service plan signed by R1 on October 25, 2022, noted R1 received services including assistance with bathing, grooming, dressing, and medication administration. R1's Memory Care Agreement signed by R1 on June 23, 2022, lacked the above required content. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet.	0 920		

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0 920	Continued From page 43 R2's unsigned service plan dated March 12, 2023, noted R2 was mobile with a wheelchair, and received services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's Memory Care Agreement signed by R2's daughter on June 21, 2022, lacked the above required content. On April 12, 2023, at approximately 10:45 a.m., assisted living director in residency (ALDIR)-C stated for all residents who received payment through a waiver, the fees information was not included on the contract. In addition, ALDIR-C stated the information on the ability to provide specialized diets was not included on any of the contracts. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of:	0 930		

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0 930	Continued From page 44 (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide a contract to include: - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is	0 930		

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0 930	Continued From page 45 required for a transfer. R1 R1's diagnoses included hypertension and depression. R1's service plan signed by R1 on October 25, 2022, noted R1 received services including assistance with bathing, grooming, dressing, and medication administration. R1's Memory Care Agreement signed by R1 on June 23, 2022, lacked the above required content. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's unsigned service plan dated March 12, 2023, noted R2 was mobile with a wheelchair, and received services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's Memory Care Agreement signed by R2's daughter on June 21, 2022, lacked the above required content. On April 12, 2023, at approximately 10:45 a.m., assisted living director in residency (ALDIR)-C stated the contract lacked the information on the transfer of residents within the facility with the required content noted above. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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0 930	Continued From page 46 information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract's arbitration provision did not preclude, limit, or delay the ability of a resident from taking civil action. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 980		

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0 980	Continued From page 47 The licensee's Memory Care Agreement included on page 15, section 35 titled Mandatory and Binding Arbitration which indicated "Any dispute, claim or controversy arising out of or relating in any way to this agreement or the breach, termination, enforcement, interpretation or validity thereof, or the provisions of services or occupancy herunder {SP}, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by binding arbitration in Rochester, MN [Minnesota] before three (3) arbitrator(s). The arbitration shall be administered by Jams pursuant to its comprehensive arbitration rules and procedures (or if Jams arbitration shall not be available for any reason, then pursuant to the general arbitration rules of any nationally recognized arbitration forum). Judgment on the award entered in any arbitration hereunder may be entered in any court having jurisdiction of the parties. This clause shall no {SP} preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction". On April 12, 2023, at approximately 10:45 a.m., assisted living director in residency (ALDIR)-C stated the current contract did contain the above content related to arbitration and was in the process of being revised. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		

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01370	Continued From page 48	01370		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01370	Continued From page 49 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-E's employee record contained an orientation checklist which listed various training. However, the record lacked documented evidence of the following required training: - reporting of changes in the resident's condition to the supervisor designated by the facility; and - maintenance of a clean and safe environment. ULP-F ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility.	01370		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01370	Continued From page 50 ULP-F's employee record contained an orientation checklist which listed various training. However, the record lacked documented evidence of the following required training: - maintenance of a clean and safe environment. On April 13, 2023, at 9:05 a.m., clinical nurse supervisor (CNS)-A said the employee records lacked the above required training, and had gotten missed. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training and competency evaluations for all ULPs would include reporting changes in the resident's condition to the supervisor designated by the facility and maintenance of a clean and safe environment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	01380		

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01380	Continued From page 51 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-F's employee record contained an orientation checklist which listed various training. However, the record lacked documented evidence of the following required training: - recognizing physical, emotional, cognitive, and developmental needs of the resident. On April 13, 2023, at 9:05 a.m., clinical nurse supervisor (CNS)-A said the employee record lacked the above required training, and had gotten missed.	01380		

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01380	Continued From page 52 The licensee's Competency Training Evaluations policy dated August 1, 2021, noted training and competency evaluations for all ULPs would include reporting changes in the resident's condition to the supervisor designated by the facility and maintenance of a clean and safe environment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440		

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01440	Continued From page 53 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for two of two unlicensed personnel (ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E and ULP-F's records lacked evidence to document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks. ULP-E ULP-E was hired on April 29, 2022, to provide direct care services to residents of the facility. On April 11, 2023, at 7:06 a.m., ULP-E was observed providing medication administration to R5. ULP-E's employee record lacked the above required content.	01440		

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01440	Continued From page 54 ULP-F ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility. On April 12, 2023, at 1:45 p.m., ULP-F was observed providing medication administration to R5. ULP-F's employee record lacked the above required content. On April 13, 2023, at 9:05 a.m., clinical nurse supervisor (CNS)-A said the employee records lacked documentation of the direct supervision, and it was not available from the prior owner. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	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;	01470		

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01470	Continued From page 55 (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 employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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01470	Continued From page 56 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 interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for three of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-E, ULP-F). 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: CNS-A CNS-A was hired on October 18, 2022, to provide direct care services to residents of the facility and supervise staff. CNS-A's employee record lacked documented evidence of the following: - an overview of the Assisted Living statutes.	01470		

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01470	Continued From page 57 ULP-E ULP-E was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following: - an overview of the Assisted Living statutes. ULP-F ULP-F was hired on April 29, 2022, to provide direct care services to residents of the facility. ULP-F's employee record lacked documented evidence of the following: - an overview of the Assisted Living statutes. On April 13, 2023, at approximately 9:05 a.m., CNS-A stated none of the licensee's employees had received the required training to include an overview of the Assisted Living statutes. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, noted all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents, and noted the training must include an overview of the appropriate Assisted Living statutes and rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01620	Continued From page 58 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 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) assessed one of one resident (R3) with falls, for causative factors to determine individualized interventions to reduce the resident's risk for injury. 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01620	Continued From page 59 has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 admitted to the facility on December 9, 2022, and discharged to the veterans affairs (VA) on March 2, 2023. R3's diagnoses included Parkinson's disease, diabetes mellitus type II, hypertension, and Alzheimer's disease. R3's unsigned service plan dated February 10, 2023, noted services including assistance with bathing, incontinence care, and medication administration. R3's comprehensive assessment dated December 9, 2022, noted R3 had a shuffling gait, utilized a walker and required one person assist with transfers, ambulation, and bed mobility. It also noted R3 was incontinent of bowel and bladder and required assistance with toileting. In addition, the assessment noted the resident had fallen in the last three months and was on safety checks every hour. R3's Fall Risk Assessment dated December 9, 2022, noted R3 utilized a walker, had 1-2 falls in the last 90 days, had periods of altered perception or awareness of surroundings, periods of lethargy, and wandered, with a total score of 18, with 7 plus points identified as a high fall risk. R3's Incident Report Resident Forms noted the following: - January 8, 2023, at 7:50 p.m., R3 was found on the floor in his bedroom. Said he hit his head. Checked for blood or injury and help off the floor.	01620		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01620	Continued From page 60 RN notified. No new interventions. - January 13, 2023, at 10:00 a.m., R3 was found on the floor in his bedroom. Staff walking by and heard his head hit the floor. Had been lethargic with low blood pressure at 9:00 a.m., and staff was on the way to check on him when he fell. Injuries noted included swelling, pain, abrasion, and hit head. Paramedics called to assess the head injury, and stopped the bleeding. RN notified. Last sheet missing with potential interventions and nurse's signature. - January 17, 2023, at unknown time on the night shift. R3 had an alleged fall in his bedroom, per resident's report. RN not notified. - February 5, 2023, at unknown time. R3 had an alleged fall in the hallway. Injuries noted included pain and hit head. RN not notified. - February 5, 2023, at 7:15 p.m., R3 had a witnessed fall at the main office. Noted staff was grabbing walker for resident at the time of the fall. Injuries noted hit head. RN not notified. - February 21, 2023, at 8:30 p.m., R3 had an alleged fall in the dining room. Noted R3 slid while trying to get up off the chair. No noted injuries, reminded to ask for help. RN not notified. On April 10, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated when she was looking at the incident report binder to provide to the surveyor, she noted the incident reports had not been completed correctly, indicating some follow up had been done by the nursing staff, but not all were finished correctly. CNS-A stated she had provided staff education prior to coming in with the binder. On April 12, 2023, at 8:55 a.m., CNS-A stated staff are expected to notify the nurse with any fall, and nursing should be documenting on the incident report any follow up, and this had not	01620		

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01620	Continued From page 61 been done. CNS-A stated they do not do a falls assessment after each fall, but should be looking at the cause of the fall and any new interventions to put into place. The licensee's Incident Report policy dated August 1, 2021, noted any incident to a resident, visitor, staff or property should be reported to the management, and an incident report should be completed. It noted if the incident happened outside business hours, the person completing the incident report must notify the RN on-call. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	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 must be entered into the resident record,	01640		

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01640	Continued From page 62 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 interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of two residents (R1, 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 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: R1 R1's diagnoses included unspecified kidney failure and vascular dementia. R1's service plan dated January 23, 2023, noted services including assistance with showering, grooming, incontinence care, and medication administration. The service plan was signed by R1, but lacked a signature or other authentication by the facility, documenting agreement on the services to be provided. R2 R2's diagnoses included hypertension,	01640		

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01640	Continued From page 63 hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's service plan dated March 12, 2023, noted R2 was mobile with a wheelchair, and received services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. However, the service plan lacked a signature or other authentication by the resident and by the facility, documenting agreement on the services to be provided. On April 12, 2023, at approximately 9:40 a.m., clinical nurse supervisor (CNS)-A stated not all service plans were signed by the resident or resident's representative, and none of the service plans were signed by the facility. The licensee's Service Plan policy dated August 1, 2021, noted the service plan and any revisions shall include a signature or other authentication by the facility and the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 64 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01650		

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01650	Continued From page 65 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included unspecified kidney failure and vascular dementia. R1's service plan dated January 23, 2023, noted services including assistance with showering, grooming, incontinence care, and medication administration. The service plan lacked: - the schedule and methods of monitoring assessments of the resident; and - a contingency plan including the identification of and information as to who has authority to sign for the resident in an emergency. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's service plan dated March 12, 2023, noted services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. The service plan lacked: - the schedule and methods of monitoring assessments of the resident; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 12, 2023, at approximately 9:10 a.m., clinical nurse supervisor (CNS)-A stated the	01650		

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01650	Continued From page 66 language related to the schedule and methods of monitoring assessments of the resident included the language from the comprehensive license, and not the assisted living license. In addition, CNS-A stated R1's plan lacked the identification of and who had the authority to sign for the resident in an emergency. At approximately 9:40 a.m., CNS-A stated R2's record lacked the resident's code status. The licensee's Service Plan policy dated August 1, 2021, noted the service plan would include the schedule and method for the next planned assessment or monitoring, and a contingency plan that included identification and contact information of who the resident had authorized to sign for the resident in an emergency, and circumstances when emergency medical services were not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700		

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01700	Continued From page 67 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for two of two residents (R1, 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 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 April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided	01700		

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01700	Continued From page 68 medication management services to their residents. R1 and R2's records lacked documented evidence the RN conducted a medication assessment to include: - identification and review of all medications the resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address those issues. R1 R1's diagnoses included unspecified kidney failure, hypertension, and muscle weakness. R1's service plan dated January 23, 2023, noted services including medication administration. R1's Medication/Treatment/Therapy Assessment & Plan dated March 10, 2023, noted R1 required administration of medications. However, it lacked the above required content. R1's unsigned prescriber orders dated March 28, 2023, included one pain reliever, two antihypertensives, and two antidepressants. R1's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through April 12, 2023, to indicate the medications had been given. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side,	01700		

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01700	Continued From page 69 anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's Medication/Treatment/Therapy Assessment & Plan dated March 10, 2023, noted R2 required administration of medications. However, it lacked the above required content. R2's service plan dated March 12, 2023, noted services including medication administration. R2's unsigned prescriber orders dated April 1, 2023, included one anticonvulsant and one antidepressant. R2's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through April 12, 2023, to indicate the medications had been given. On April 12, 2023, at approximately 9:10 a.m., CNS-A stated she reviewed the residents medications but did not document the required content for any of the residents. The licensee's Assessment Schedules policy dated August 1, 2021, noted the medication management schedule would be completed prior to providing medication management services, when the resident presented with symptoms or issues that may be related to medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01730	Continued From page 70	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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01730	Continued From page 71 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, 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 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 April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to their residents. R1 and R2's records lacked documented evidence of a medication reconciliation. R1 R1's diagnoses included unspecified kidney failure and vascular dementia. R1's service plan dated January 23, 2023, noted services including medication administration.	01730		

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01730	Continued From page 72 R1's Medication/Treatment/Therapy Assessment & Plan dated March 10, 2023, noted R1 required administration of medications. However, it lacked documented evidence of a medication reconciliation. R1's unsigned prescriber orders dated March 28, 2023, included one pain reliever, two antihypertensives, and two antidepressants. R1's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through April 12, 2023, to indicate the medications had been given. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's Medication/Treatment/Therapy Assessment & Plan dated March 10, 2023, noted R2 required administration of medications. However, it lacked documented evidence of a medication reconciliation. R2's service plan dated March 12, 2023, noted services including medication administration. R2's unsigned prescriber orders dated April 1, 2023, included one pain reliever, two antihypertensives, and two antidepressants. R2's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials	01730		

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01730	Continued From page 73 through April 12, 2023, to indicate the medications had been given. On April 12, 2023, at approximately 9:10 a.m., CNS-A indicated a medication reconciliation had not been documented in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a 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,	01790		

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01790	Continued From page 74 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP)	01790		

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	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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01790	Continued From page 75 providing medications for residents having unplanned time away 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 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 April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents. The licensee's LOA (Leave of Absence) Medication Instructions form lacked identification of how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each returned medication. On April 12, 2023, at 9:10 a.m., CNS-A said the written procedure lacked the above required content. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, noted the written procedures for giving medications to resident would include how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each	01790		

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01790	Continued From page 76 medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1 and 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 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 April 10, 2023, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to their	01820		

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01820	Continued From page 77 residents. R1 R1's diagnoses included unspecified kidney failure and vascular dementia. R1's service plan dated January 23, 2023, noted services including assistance with showering, grooming, incontinence care, and medication administration. R1's prescriber orders dated March 28, 2023, included one pain reliever, two antihypertensives, and two antidepressants; however the orders lacked a written or electronic signature by the provider. R1's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through April 12, 2023, to indicate the medications had been given. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's service plan dated March 12, 2023, noted services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's prescriber orders dated April 1, 2023, included one anticonvulsant and one antidepressant; however the orders lacked a written or electronic signature by the provider.	01820		

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01820	Continued From page 78 R2's April 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through April 12, 2023, to indicate the medications had been given. On April 12, 2023, at approximately 9:10 a.m., CNS-A indicated the provider service utilized by the licensee had their orders on the "bridge", however, they lacked an electronic signature. The licensee's Medication Administration Program policy dated February 1, 2022, noted the licensee would maintain a current list of medications in conjunction with the signed prescriber orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 79 by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 10, 2023, at approximately 1:15p.m., the Assisted Living Director in training (ALDIR)-C could not provide documents for review. The HVA Dementia Care Tool 2022 was not provided and could not be verified for hazards or safety risks identified on and around the property with mitigation of property hazards to protect residents from harm. On April 10, 2023, at approximately 1:15p.m., the ALDIR-C confirmed during the exit interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02170	Continued From page 80	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 81 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for two of two residents (R1, R2) who resided in an assisted living with dementia care 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective June 1, 2022. R1 R1's diagnoses included unspecified kidney failure, hypertension, and muscle weakness. R1's service plan dated January 23, 2023, noted services including assistance with showering, grooming, incontinence care, and medication administration. R1's comprehensive assessment dated March 10, 2023, noted under activities, the resident enjoyed visiting with other residents and watching television. However, it lacked an evaluation to include: - current abilities and skills;	02170		

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02170	Continued From page 82 - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's comprehensive assessment dated March 10, 2023, noted under activities, the resident enjoyed sleeping and watching television. However, it lacked an evaluation to include: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, the record lacked an individualized activity plan to include a selection of daily structured and non-structured activities. On April 12, 2023, at approximately 9:10 a.m., clinical nurse supervisor (CNS)-A stated the activity evaluations lacked the required content, and the records lacked an individualized activity plan for all residents.	02170		

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02170	Continued From page 83 The licensee's Activity Programming policy dated August 1, 2021, noted the lacking information on the activity evaluation or individualized activity plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms	02180		

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02180	Continued From page 84 identified were addressed on the service plan for two of two residents (R1, 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective June 1, 2022. R1 R1's diagnoses included unspecified kidney failure, hypertension, and muscle weakness. R1's service plan dated January 23, 2023, noted services including assistance with showering, grooming, incontinence care, and medication administration. R1's flowsheet for March 2023 identified by clinical nurse supervisor (CNS)-A as the form staff utilized to sign off on services provided, noted "Behavior Monitoring & Interventions Observe for behaviors, wandering, etc. and report to RN [registered nurse] if noted". It also noted as needed. The form contained staff signatures on several days, but lacked identification of the behavior or the intervention utilized. R2 R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral	02180		

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02180	Continued From page 85 infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's service plan dated March 12, 2023, noted services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's flowsheet for March 2023 noted "Behavior Monitoring & Interventions". It also noted as needed. The form contained staff signatures on several days, but lacked identification of the behavior or the intervention utilized. On April 12, 2023, at approximately 9:10 a.m., CNS-A stated the documentation did not include what the behaviors were, or any interventions the staff could utilize with the behaviors. The licensee's Behavioral Symptoms, Interventions & Nonpharmacological Approaches policy dated August 1, 2021, noted the licensee would identify behavioral symptoms that negatively impact other residents and evaluate to determine potential interventions to minimize such behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02310 SS=I	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	02310		4/12/23

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02310	Continued From page 86 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R4 and R2) with a hospital bed with bedrails, and for one of one resident (R2) with an assistive device in addition to a hospital bedrail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HOSPITAL-STYLE BEDRAILS On April 11, 2023, at 10:55 a.m., clinical nurse supervisor (CNS)-A provided an updated resident roster to include two residents with bedrails. R4 On April 11, 2023, at 10:05 a.m., with R4's permission, the evaluator observed unlicensed personnel (ULP)-E and ULP-F provide cares to R4 in his room. The ULP's assisted R4 with clothing, perineal cares, and to put on a clean incontinence brief. During this time, the ULP's turned R4 from side to side, and boosted R4 up in	02310	An immediate correction order was identified on April 11, 2023, issued for SL 30601015, tag identification 2310 at 5:56 p.m.. On April 12,2023, the immediacy of correction order 2310 was removed at 2:07 p.m.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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02310	Continued From page 87 bed after cares were completed. At no time did R4 attempt to use the bedrails. The bedrails were lowered during the cares by the ULPs. R4 stated he does not utilize the bedrails, and was not sure what they were for. On April 11, 2023, at 12:56 p.m., the evaluator and CNS-A entered R4's room while R4 was in the dining room eating lunch. R4's hospital bed had bilateral dark brown metal bedrails in the raised position, neither side was against the wall. Both bedrails were securely affixed to the bed. The evaluator observed CNS-A measure the bedrails. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 4.0 inches. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bedrail for zone 3, measured 2.0 inches. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. R4's diagnoses included Parkinson's disease and Alzheimer's disease. R4's unsigned service plan dated March 23, 2023, noted R4 was non-ambulatory and was unable to exit the building without total assistance, and required safety checks every two hours for falls. It also noted R4 received services including assistance with bathing, grooming, dressing, medication administration, and incontinence care. R4's Global Deterioration Scale dated March 10, 2023, noted R4 had a very severe cognitive decline, to include all verbal abilities lost, may have spontaneous verbalizations, frequently no speech at all, only grunting.	02310		

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02310	Continued From page 88 R4's Bedrail Assessment dated March 10, 2023, noted: - the rationale for potential use was for safety, predisposing factors listed as weakness, spontaneous body movement, limited trunk strength in the sitting position, non-weight bearing, fear of rolling out of bed, use of other physical devices, provide a sense of security, poor safety awareness, and agitation; - the purpose to assist with turning from side to side in bed and self-positioning in bed, to assist with stabilization of transfers in and out of bed, to assist to define the bed edges, to provide a feeling of comfort and security, to assist in improving strength in upper extremities and allow maximum resident participation, to assist in pulling self up from a laying to sitting position, and to assist in pulling and holding self over on one side; - the risks of the bedrails; and - a quarter bedrail on both upper sides of the bed. R4's Bedrail - Intended Purpose and Potential Risks form dated March 10, 2023, noted: - the purpose to assist with turning from side to side in bed and self-positioning in bed, to assist to define the bed edges, and to provide a feeling of comfort and security; and - potential risks included to create a source of known morbidity and mortality such as strangling, suffocation, serious bodily injury, and death when residents or parts of their bodies are caught between the rails, openings in the rails or between the bedrails and mattress; bedrails could impede a resident from safely getting out of bed, as they may crawl over the rail and fall from a greater height, increasing the risk for serious injury, or could attempt to get out of bed over the foot board; bedrails and risks associated with	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 89 them could be exacerbated by improper match of the bedrail to the frame or improper installation, and could increase the risk of head trauma, bruising, contusions and/or lacerations, fracture and/or dislocations if not properly assessed. The form had R4's spouse's name typed in under signature, and was dated March 12, 2023. R4's comprehensive assessment dated March 10, 2023, noted R4 was unable to make needs understood, and staff were to anticipate needs and ask yes / no questions. It noted R4 was non-ambulatory and preferred assist of two staff with a mechanical lift, and was unable to exit the building without total physical assistance. It noted R4 was not oriented and was not capable of independent decision making. In addition, it noted R4 was incontinent of bladder and bowel, and utilized incontinence products. The assessment noted R4 transferred with a mechanical lift/hoyer, was unable to bear weight, and transferred with the assistance of two staff and the hoyer lift, and assist of two for turning or repositioning in bed. It noted R4 did not participate in the turning and repositioning. R4's record lacked documentation of measurements to ensure the bedrails were consistent with the Food and Drug Administration (FDA) guidelines. Additionally, R4's record lacked evidence the licensee ensured the bedrails were installed per manufacturer's guidelines. HOSPITAL-STYLE BEDRAILS & CONSUMER BEDRAIL R2 On April 11, 2023, at 1:05 p.m., the evaluator and CNS-A entered R2's room. R2 was lying in bed on his right side facing away from the wall, and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 90 gave permission for review of his bedrails. R2's hospital bed had a dark brown hospital-style metal bedrail in the raised position on the left side of the bed. A pillow was propped between R2 and the bedrail. The left side of the bed was against the wall. The bedrail was securely affixed to the bed. The evaluator observed CNS-A measure the bedrails. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 4.0 inches. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bedrail for zone 3, measured 2.0 inches. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. R2 also had a consumer rail securely attached to the right side of the bed. It had a sticker on it which read Midwest Companies, with a phone number listed. No product model name or information was noted. R2 stated he did not use the hospital bedrail on the left side of his bed, and it was always in the upright position. R2 stated he utilized the consumer rail to get in and out of bed, and to position himself in bed. R2's diagnoses included hypertension, hemiplegia, and hemiparesis following a cerebral infarction affecting the left non-dominant side, anxiety disorder, rheumatoid arthritis, and unsteadiness on his feet. R2's unsigned service plan dated March 12, 2023, noted R2 was mobile with a wheelchair, and received services including assistance with application and removal of a brace, catheter cares, medication administration, and dressing. R2's Global Deterioration Scale dated March 10,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 91 2023, noted R2 had moderate cognitive decline, to include a decreased knowledge of current events, may exhibit some deficit in memory of personal history, concentration deficit, and a decreased ability to travel. R2's Bedrail Assessment dated September 8, 2022, noted R2 was independent with bed mobility, the purpose and risk of the bedrails. In addition, it noted the bedrail model and manufacturer as a Halo. The type of bedrail was noted to be a quarter bedrail, with the location marked as the left upper side and right upper side. It noted the bedrails were FDA compliant and not considered a restraint. R2's Bedrail Assessment dated March 10, 2023, noted: - the rationale for potential use was for a medical condition; - the purpose to assist with stabilization of transfers in and out of bed; - the risks of the bedrails; and - a quarter bedrail on the right upper side of the bed. R2's Bedrail - Intended Purpose and Potential Risks form dated March 10, 2023, noted: - the purpose to assist with turning from side to side in bed and self-positioning in bed, to assist with stabilization of transfer in and out of bed, to assist to define the bed edges, and to provide a feeling of comfort and security, and assist in improving strength in upper extremities and allow maximum resident participation with bed mobility and transfers; and - potential risks included to create a source of known morbidity and mortality such as strangling, suffocation, serious bodily injury, and death when residents or parts of their bodies are caught	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

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02310	Continued From page 92 between the rails, openings in the rails or between the bedrails and mattress; bedrails could impede a resident from safely getting out of bed, as they may crawl over the rail and fall from a greater height, increasing the risk for serious injury, or could attempt to get out of bed over the foot board; bedrails and risks associated with them could be exacerbated by improper match of the bedrail to the frame or improper installation, and could increase the risk of head trauma, bruising, contusion,s and/or lacerations, fracture and/or dislocations if not properly assessed. The form had R2's daughter's name typed in under signature, and dated March 12, 2023. R2's comprehensive assessment dated March 10, 2023, noted R2 utilized a walker and wheelchair, required one person assistance with transfers and ambulation. It noted R2's orientation fluctuates throughout the day, was incontinent of bowel and had a catheter. In addition, it note R2 required assistance of one staff to turn or reposition in bed. R2's record lacked documentation of measurements to ensure the hospital-style bedrails were consistent with the Food and Drug Administration (FDA) guidelines. In addition, it lacked documentation that the device was installed per manufacturer's guidelines or that the licensee referred to the CPSC for the most up-to-date information related to portable bed side rail recall information. On April 11, 2023, at 12:45 p.m., CNS-A stated she did not have the measurements for R4 or R2's bedrails. She stated she had them for other sites, but not for here. On April 11, 2023, at 1:30 p.m., CNS-A stated she	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 93 was unable to locate the manufacturer instructions for use for the consumer rail, but they were in the process of calling the company. In addition, CNS-A stated she was aware of the requirement to check for a recall, but stated it had not been done to her knowledge and was unaware of how to check for a recall. The licensee's Side rails (Bedrails) policy dated effective/revised August 1, 2023, noted when the licensee was aware a resident was utilizing a medical device on a bed, they would assess the use educate the resident/responsible person, regarding the risks and benefits of the device, and verify the it was of a safe design and utilized consistent with the manufacturer's directions. It noted the nurse would assess the bedrail to ensure it was used consistent with the manufacturer's directions, ensure it was installed securely and maintained in good operating condition, and ensure the design was consistent with the FDA's 2006 recommended dimensional measurement to reduce entrapment. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 94 between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveryor's on-site observations and review by evaluation supervisor on April 12, 2023, however non-compliance remains at a scope and leve of level three, widespread (I).	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *04/10/23*
Time: 11:00:34
Report: 1037231095

Food and Beverage Establishment Inspection Report

Location:
Landings At Sauk Rapids
1325 Summit Avenue North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0037540
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203161604
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

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

PREVIOUSLY ISSUED 12/18/19. AT TIME OF INSPECTION, DISHWASHER WAS READING A CHLORINE CONCENTRATION OF 0 PPM. DISCONTINUE USING THE DISHWASHER UNTIL UNIT IS WORKING PROPERLY.

Comply By: 04/10/23

2-100 Supervision

2-102.12AMN

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

TAMIE GLOVER HAS A SERVESAFE CERTIFICATE POSTED IN THE KITCHEN FROM JAN 2023. DISCUSSED WITH TAMIE SENDING IN HER CFPM APPLCIATION, FEE, AND TEST RESULTS WITHIN 6 MONTHS OF THE EXAM. APPLICATION ATTACHED WITH REPORT.

Comply By: 07/01/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

ICE DAMPER IN THE INTERIOR OF ICE MAKER IS BROKEN. REMOVE BROKEN PLASTIC AND REPAIR ICE MAKER.

Comply By: 04/24/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

INTERIOR OF ICE MAKER HAS MOLD. CLEAN INTERIOR OF ICE MAKER AND MAINTAIN CLEAN.

Comply By: 04/17/23

Surface and Equipment Sanitizers

Chlorine: = 0 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: PRECOOKED BRATWURST
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

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

Type: Full
Date: *04/10/23*
Time: 11:00:34
Report: 1037231095
Landings At Sauk Rapids

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1037231095 of 04/10/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
TAMIE GLOVER

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231095

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 04/10/23
Time In 11:00:34
Time Out

Landings At Sauk Rapids	Address: 1325 Summit Avenue North	City/State: Sauk Rapids, MN	Zip Code: 56379	Telephone: 3203161604
License/Permit #: 0037540	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 04/10/23

Inspector (Signature) Michelle L Hoversos