Electronically Delivered

October 22, 2024

Licensee
Bridgeway Estates
103 12th Street Northeast
Little Falls, MN 56345

RE: Project Number(s) SL30385015

Dear Licensee:

On October 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 21, 2024, survey and the July 17, 2024, follow-up survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 7, 2024

Licensee
Bridgeway Estates
103 12th Street Northeast
Little Falls, MN 56345

RE: Project Number(s) SL30385015

Dear Licensee:

On July 17, 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 on May 21, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 21, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 1, 2024, found not corrected at the time of the July 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on July 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.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you 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

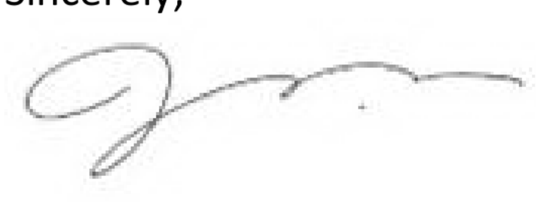
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30385	A. BUILDING: _____ B. WING _____	R 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

(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: SL #30385015-1 On July 11, 2024, through July 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 21, 2024. At the time of the survey, there were 45 residents; 19 receiving services under the Assisted Living license. As a result of the follow-up survey, the following order was 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (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: No further action required	{0 480}		
{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: 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,	{0 810}		

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{0 810}	Continued From page 2 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: No further action required.	{0 810}		
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 950}	Continued From page 3 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action required.	{0 950}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01290}	Continued From page 4 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study had been submitted for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-D). In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) number for three of three employees (ULP-E, ULP-G, ULP-H). This had the potential to affect all residents living within the facility. 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: BACKGROUND STUDY SUBMISSION ULP-B ULP-B was hired on December 27, 2022, and began providing assisted living services. The licensee's Net Study 2.0 report run on July 11, 2024, at approximately 3:00 p.m., indicated ULP-B's Net Study 2.0 background study was	{01290}		

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{01290}	Continued From page 5 submitted on July 11, 2024, at 10:45 a.m. (after initiation of the survey). The Net Study 2.0 report indicated ULP-B's affiliation with licensee had expired on June 6, 2024, and ULP-B had no active affiliations from June 6, 2024, through July 11, 2024. The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-B was scheduled on June 7, 8, 9,10, 13, 17, 18, 19, 22, 23, 27, and 28, 2024 and July 5, 6, 7, 10, and 11, 2024, without a submitted background study. ULP-C ULP-C was hired on June 19, 2023, and began providing assisted living services. The licensee's Net Study 2.0 report run on July 11, 2024, at approximately 3:00 p.m., indicated ULP-C's Net Study 2.0 background study was submitted on July 11, 2024, at 1:39 p.m. (after initiation of the survey). The Net Study report indicated ULP-C's affiliation with licensee's HFID had expired on June 6, 2024, and ULP-C had no active affiliations from June 6, 2024, through July 11, 2024. The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-C was scheduled on June 14, 15, 16 and 28, 2024 and July 3, 2024, without a submitted background study. ULP-D ULP-D was hired on February 15, 2024, and began providing assisted living services. The licensee's Net Study 2.0 report run on July	{01290}		

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{01290}	Continued From page 6 11, 2024, at approximately 3:00 p.m., indicated ULP-D's Net Study 2.0 background study was submitted on July 11, 2024, at 1:10 p.m. (after initiation of the survey). The Net Study 2.0 report indicated ULP-D had no active affiliations from May 1, 2024, through July 11, 2024. The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-B was scheduled on May 27, 28, and 31, 2024, June 1, 2, 5, 6, 11, 12, 14, 15, 16, 20, 21, 24, 25, 26, 29, and 30, 2024, and July 3, 4, 8, and 9, 2024, without a submitted background study. BACKGROUND AFFILIATION ULP-E ULP-E was hired on June 19, 2023, and began providing assisted living services. The licensee's Net Study 2.0 report run on July 11, 2024, at approximately 3:00 p.m., indicated ULP-E was affiliated with licensee on July 11, 2024, at 1:11 p.m. (after initiation of the survey). The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-E was scheduled and worked on June 7 and 22, 2024, without an affiliated background study to licensee's HFID. ULP-G ULP-G was hired on January 11, 2024, and began providing assisted living services. The licensee's Net Study 2.0 report run on July 11, 2024, at approximately 3:00 p.m., indicated ULP-G was affiliated with licensee on July 11, 2024, at 12:59 p.m. (after initiation of the survey).	{01290}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

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{01290}	Continued From page 7 The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-G was scheduled and worked on May 27 and 28, 2024, June 3, 4, 5, 11, 12, 13, 17, 18, 19, 20, and 25, 2024, and July 2, and 9, 2024, without an affiliated background study to licensee's HFID. ULP-H ULP-H was hired on May 10, 2024, and began providing assisted living services. The licensee's Net Study 2.0 report run on July 11, 2024, at approximately 3:00 p.m., indicated ULP-H was affiliated with licensee on July 11, 2024, at 1:02 p.m. (after initiation of the survey). The licensee's schedules dated May 27, 2024, through July 21, 2024, indicated ULP-H was scheduled and worked on May 27, 28, and 31, 2024, June 1, 2, 4, 5, 6, 8, 10, 14, 16, 20, 24, 28, 29, and 30, 2024, and July 6, and 8, 2024, without an affiliated background study to licensee's HFID. On July 11, 2024, at approximately 8:00 a.m., Minnesota Department of Health (MDH) initiated a survey with licensee to follow up on a citation issued for tag identification number 1290 during a survey previously exited on May 21, 2024. On July 16, 2024, at approximately 11:05 a.m., human resources (HR)-F stated ULP-D, ULP-E, and ULP-F's background studies had been closed and they became aware of it when they accessed their Net Study account on July 11, 2024. HR-F stated they had been unable to access their Net Study 2.0 account prior to July 11, 2024, due to Net Study maintenance.	{01290}		

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{01290}	Continued From page 8 On July 16, 2024, at approximately 11:05 a.m., HR-F also stated they had previously affiliated ULP-E, ULP-G, and ULP-H to the licensee's HFID and noted that the affiliations were missing from the roster when they accessed their account on July 11, 2024. The licensee's undated Immediate Plan of Correction indicated all employees would be affiliated with licensee's HFID by the end of the day on May 21, 2024. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated a background study check must be conducted on all prospective individuals who will have access to individuals receiving services and will be completed through DHS. In addition, the background study will be affiliated with entity's HFID. No further information was provided.	{01290}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	{01640}		

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{01640}	Continued From page 9 (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: No further action required.	{01640}		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: No further action required	{01770}		

Electronically Delivered

June 5, 2024

Licensee
Bridgeway Estates
103 12th Street Northeast
Little Falls, MN 56345

RE: Project Number(s) SL30385015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30385	A. BUILDING: _____ B. WING _____	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

(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 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: SL30385015 On May 20, 2024, through May 21, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 45 residents; 17 receiving services under the provider's Assisted Living license. An immediate correction order was identified on May 21, 2024 for SL30385015, tag identification 1290. On May 21, 2024, at 12:45 p.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of I.	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.	
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) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 20, 2024, 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		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 2 (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 maintain 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. This deficient condition 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). The findings include: On May 20, 2024, at 12:00 p.m., survey staff toured the facility with maintenance director (MD)-C. It was observed that the closer arms on the fire-rated doors into the laundry rooms had been removed on first, second, and third floor. Fire-rated doors to high-hazard areas should close and positively latch to maintain the fire resistance integrity of the assembly. This deficient	0 800		

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0 800	Continued From page 3 condition was visually verified by MD-C accompanying on the tour. During interview on May 20, 2024, at 3:30 p.m., MD-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 4 (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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 20, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and licensed practical nurse (LPN)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety, Procedures and Evacuation Plan", dated September 07, 2023, failed to include the	0 810		

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0 810	Continued From page 5 following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but the plan was written for and referenced the "care center" attached to this facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on May 20, 2024, at 3:30 p.m., registered nurse (RN)-E stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD/CNS-A and LPN-D were unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on May 20, 2024, at 3:30 p.m., LALD/CNS-A and LPN-D stated they understood the requirements and would	0 810		

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0 810	Continued From page 6 implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R6, R2) assisted living contracts included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at 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: R6 R6's service plan dated November 10, 2023, indicated R6 received medication administration, housekeeping, and laundry. On May 21, 2024, at 7:44 a.m., the surveyor observed unlicensed personnel (ULP)-B provide scheduled morning medication administration to R6. R2 R2's service plan dated June 13, 2022, indicated R2 received a blood sugar check daily, medication administration/medication reminders, housekeeping, and laundry. R6 and R2's record contained the following notice on Page 18 of the Assisted Living Contract: Resident has the right to name an individual of	0 950		

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0 950	Continued From page 8 their choice as "Designated Representative" for the purposes of receiving certain information and to whom Provider [sic] can go to with questions related to Resident's [sic] residency and care at (licensee's name). If a Responsible Person is party to this Contract and Resident fails to name and provide contact information for a Designated Representative, Provider will direct questions related to Resident's residency and car at (licensee's name) to the Responsible Person. Resident may name as [sic] Resident's Designated Representative an individual serving as Resident's Responsible Person. Resident also has the right to decline to name a Designated Representative, regardless of whether an individual has agreed to execute this Contract as Resident's Responsible Person. R6 and R2's Assisted Living Contract dated September 18, 2023, and August 31, 2023, respectively, contained a summary of a designated representative as noted above, however, lacked required statutory verbiage. On May 21, 2024, at 9:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the designated representative information written in the assisted living contract did not meet the statutory language required and was not aware of the requirement. LALD/CNS-A further stated the same designated representative notice was given to all residents at the facility. On May 21, 2024, at 10:36 a.m., registered nurse (RN)-E stated the licensee was not using the updated designated representative form with the correct designated representative verbiage. No further information was provided.	0 950		

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0 950	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for one of three employees (unlicensed personnel (ULP)-B). In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for two of two employees. This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290		

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01290	Continued From page 10 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: This resulted in an immediate correction order on May 21, 2024. On May 20, 2024, at 11:33 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of required contents in an employee record. BACKGROUND STUDY CLEARANCE ULP-B ULP-B was hired on December 27, 2022, to provide direct care services to the residents at the assisted living facility. On May 14, 2024, at 6:05 a.m., the surveyor observed ULP-B provide scheduled morning medication administration to R7. ULP-B was not under direct supervision. ULP-B's record contained a Final Registry Results Form issued by NETStudy 2.0 dated May 20, 2024, which indicated this applicant (ULP)-B had not been previously determined eligible for employment and must be fingerprinted. ULP-B's employee record lacked a cleared background study. BACKGROUND AFFILIATION	01290		

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01290	Continued From page 11 LALD/CNS-A LALD/CNS-A was licensed as a registered nurse (RN) by the Minnesota State Board of Nursing effective July 11, 2013. LALD/CNS-A was hired on August 5, 2013, and effective August 1, 2021, provided direct care services to the residents at the facility and supervision to staff at the facility. Upon review of the licensee's NETStudy Roster, LALD/CNS-A was affiliated to HFID 382, the licensee's care center identification and was cleared in NETStudy 2.0. LALD/CNS-A's record lacked documentation of a cleared background study affiliated with the facility's correct HFID. MAINTENANCE DIRECTOR (MD)-C MD-C was hired April 13, 2022, to provide maintenance needs at the assisted living facility. MD-C's record contained a cleared background study notice issued by the Minnesota Department of Human Services dated July 26, 2019. The background study was affiliated to the licensee's campus care center with the HFID 382. On May 21, 2024, at 8:16 a.m., LALD/CNS-A stated ULP-B was going to get fingerprints and a photo this morning for ULP-B's NETStudy 2.0 background study and the campus human resources was in charge of submitting background studies. LALD/CNS-A further stated the licensee was unable to locate a cleared background study for ULP-B, however, LALD/CNS-B recalled ULP-B going in at least three times for fingerprints and a photo upon hire.	01290		

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01290	Continued From page 12 On May 21, 2024, at 8:20 a.m., the surveyor reviewed the NETStudy 2.0 website and rosters with human resources (HR)-F. HR-F stated all assisted living employees were affiliated to the HFID for the campus care center as the licensee did not have access to the assisted living HFID NETStudy 2.0 roster, however, was awaiting the Minnesota Department of Human Services (DHS) to create an access for the assisted living HFID NETStudy 2.0 roster. HR-F further stated, the licensee was unable to locate a cleared background study for ULP-B and issued a new application for ULP-B yesterday after the surveyor requested to view ULP-B's cleared background study. On May 21, 2024, at 8:53 a.m., HR-F stated the licensee would be notified of an ineligible background study after an application was completed in NETStudy 2.0 for an employee. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated a background study check must be conducted on all prospective individuals who will have access to individuals receiving services and will be completed through DHS. In addition, the background study will be affiliated with entity's HFID. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling,	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30385	A. BUILDING: _____ B. WING _____	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

(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
01290	Continued From page 13 consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on May 21, 2024, at 12:45 p.m., however, non-compliance remains at a scope and level of three, widespread (l).	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

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01640	Continued From page 14 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of two residents (R6). This practice resulted in a level two 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 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: R6's service plan dated November 10, 2023, indicated R6 received medication administration, housekeeping, and laundry. On May 21, 2024, at 7:44 a.m., the surveyor observed unlicensed personnel (ULP)-B provide scheduled morning medication administration to	01640		

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BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

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01640	Continued From page 15 R6. R6's service plan lacked a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On May 21, 2024, at 10:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee did not authenticate R6's service plan after revisions were made. LALD/CNS-A stated the licensee's typical process is for LALD/CNS-A to sign a resident service plan at the same time the resident signs the service plan. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated the service plan and any revisions must include a signature with the name, title and date of the Assisted [sic] living designee and a signature or other authentication by the resident or the 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		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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	30385	A. BUILDING: _____ B. WING _____	05/21/2024

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BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

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01770	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R7, R8). 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: R7 R7's diagnoses included presence of prosthetic heart valve (one-way valve implanted into a person's heart to replace a heart valve that was not functioning properly to permit blood flow through the heart), chronic atrial fibrillation (irregular and often faster heartbeat), and other nonrheumatic mitral valve disorder (condition that affected the mitral valve (valve that separates the left atrium and the left ventricle of the heart not caused by rheumatic fever). R7's Service Plan dated February 12, 2024, included: -medication reviewed/setup by nurse and staff (unlicensed personnel/ULP) administration. R7's Monthly Task Log dated May 1, 2024, through May 20, 2024, included: -medication reviewed/setup by nurse and staff	01770		

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	30385	A. BUILDING: _____ B. WING _____	05/21/2024

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BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

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01770	Continued From page 17 administer. On May 14, 2024, at 6:05 a.m., the surveyor observed ULP-B provide scheduled morning medication administration to R7. R7's prescriber's order dated May 6, 2024, included: -six milligrams (mg) warfarin (reduces the formation of blood clots); on Monday, Wednesday, Friday. -four mg warfarin; on Tuesday, Thursday, Saturday, Sunday. Prescriber's order written for warfarin: May 6, 2024, through June 2, 2024. Date of next INR (blood test that measures the time for blood to clot,) June 3, 2024. R7's record contained "Warfarin Therapy Instructions" -May and June 2024 calendars, that included the dosages of warfarin to be given written on each calendar square (as written on prescriber order) -date of next INR June 3, 2024 -how to take: four mg, take one of the four mg tablets -how to take: six mg, take 1.5 of the four mg tablets -the initials of the nurse who setup the warfarin, and date of setup. R7's medication setup record did not include: -times to be administered -route of administration. R8 R8's diagnoses include hypertension (HTN/high blood pressure), and congestive heart failure (heart can't pump blood well enough to meet the body's needs).	01770		

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01770	Continued From page 18 R8's service plan dated October 12, 2023, included: -nurse will review medications for accuracy and set up prior to RA (resident assistant/ULP) administration. R8's Monthly Task Log dated May 1, 2024, through May 20, 2024, included: -single bubble packs and box for coumadin (blood thinner): nurse will review medications for accuracy and setup prior to ULP administration. R8's prescriber's order dated May 13, 2024, included: -one mg warfarin on Monday, Friday -two mg warfarin; on Tuesday, Wednesday, Thursday, Saturday, Sunday. Prescriber's order written for warfarin: May 6, 2024, through May 20, 2024. Date of next INR, May 20, 2024. R8's record contained "Warfarin Therapy Instructions" -May 2024 calendar included the dosages of warfarin to be given written on each calendar square (as written on prescriber order) -date of next INR June 3, 2024 -how to take: one mg, take 0.5 of a two mg tablet -how to take: two mg, take on of the two mg tablets -the initials of the nurse who setup the warfarin, and date of set up. R8's medication setup record did not include: -times to be administered -route of administration. On May 21, 2024, at 10:13 a.m., licensed practical nurse (LPN)-D and the surveyor	01770		

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	30385	A. BUILDING: _____ B. WING _____	05/21/2024

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01770	Continued From page 19 reviewed R7 and R8's medication setup records. LPN-D stated "this" is how "they" (licensee) does warfarin medication setup. LPN-D confirmed R7 and R8's medication setup record did not include all the required documentation to include the time warfarin was to be administered or the route of warfarin administration. On May 21, 2024, at 10:22 a.m., registered nurse (RN)-E explained to LPN-D that medication setup documentation needed to be done in the on-line computer system used by the licensee. RN-E stated R7 and R8's records did not include required information for medication setup. The licensee's Medication Administration System-Biweekly Dosage Box Set-Up policy dated August 31, 2023, indicated the following procedure would be followed for the Weekly Dosage Box Medication Set-Up under the Medication Administration system: a.) Medication orders are transcribed onto the Medication List. This profile included: -medication name and strength -client (resident) name -day and time of administration -route of administration -dosage of medication -visual description of medication -any specific instructions or special precautions for administering the medication to the client. The RN or LPN assured that this profile was complete and consistent with the prescription label. The RN or LPN also utilized this form for the Medication Set up Sheet. For medications included in the dosage box, the day and time the medication was set up would be noted on the Medication Set up Sheet. When the RN or LPN had completed setting up the medications into the dosage box, the setup is documented on the	01770		

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01770	Continued From page 20 Mediation Administration Record printed form the EHR (electronic health record.) The RN or LPN would review the dosage boxes on a biweekly basis to assure that all the previous week's medications were administered, and documentation was made on the weekly record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *05/20/24*
Time: 11:00:20
Report: 1037241110

Food and Beverage Establishment Inspection Report

Location:
Bridgeway Estates
103 12th Street Ne
Little Falls, MN56345
Morrison County, 49

Establishment Info:
ID #: 0037926
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 3206322089
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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

FOOD THERMOMETER ONSITE IS GOOD FOR MEASURING TEMPERATURES OF ROASTS AND SOUPS. PROVIDE A THIN/TAPERED TIPPED THERMOMETER FOR MEASURING THIN FOODS.

Comply By: 06/03/24

2-100 Supervision

2-102.12AMN

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

EMPLOY A CERTIFIED FOOD PROTECTION MANAGER AND POST THE CERTIFICATE IN A LOCATION VISIBLE TO THE INSPECTOR AT THE TIME OF INSPECTION.

Comply By: 06/20/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14F

MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.

SINGLE USE SANTIZING WIPES AND THE CLOROX SPRAY BOTTLE ARE LABELED TO RINSE AFTER DRY ON FOOD CONTACT SURFACES. DISCONTINUE USE OF THE SANITIZING WIPES AND CLOROX SPRAY BOTTLE AND PROVIDE AN APPROVED SANTIZING SOLUTION FOR FOOD CONTACT SURFACES.

Comply By: 05/20/24

Type: Full
Date: *05/20/24*
Time: 11:00:20
Report: 1037241110
Bridgeway Estates

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Hot Holding
Temperature: 185 Degrees Fahrenheit - Location: DICED POTATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: CAULIFLOWER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 195 Degrees Fahrenheit - Location: HAM
Violation Issued: No

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

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

FOODS ARE PREPARED AND SENT OVER AT THE TIME OF SERVICE TO THE SERVING KITCHEN FROM THE ADJACENT CARE CENTER.
DISCUSSED COOLING, BARE HAND CONTACT, EMPLOYEE ILLNESS REPORTING, AND ORDERS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1037241110 of 05/20/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

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

Type: Full
Date: *05/20/24*
Time: 11:00:20
Report: 1037241110
Bridgeway Estates

Food and Beverage Establishment Inspection Report

michelle.hovanes@state.mn.us

Report #: 1037241110

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/20/24
Time In 11:00:20
Time Out

	Address	City/State	Zip Code	Telephone
Bridgeway Estates	103 12th Street Ne	Little Falls, MN	56345	3206322089

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037926		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Supervision			
1	IN (OUT)		
2	IN (OUT) N/A		
Employee Health			
3	(IN) OUT		
4	(IN) OUT		
5	(IN) OUT		
Good Hygenic Practices			
6	(IN) OUT N/O		
7	(IN) OUT N/O		
Preventing Contamination by Hands			
8	(IN) OUT N/O		
9	(IN) OUT N/A N/O		
10	(IN) OUT		
Approved Source			
11	(IN) OUT		
12	(IN) OUT N/A N/O		
13	(IN) OUT		
14	IN OUT (N/A) N/O		
Protection from Contamination			
15	IN OUT (N/A) N/O		
16	(IN) OUT N/A		
17	(IN) OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT (N/A) N/O		
19	IN OUT (N/A) N/O		
20	IN OUT N/A (N/O)		
21	(IN) OUT N/A N/O		
22	(IN) OUT N/A		
23	(IN) OUT N/A N/O		
24	IN OUT (N/A) N/O		
Consumer Advisory			
25	IN OUT (N/A)		
Highly Susceptible Populations			
26	IN OUT (N/A)		
Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)		
28	(IN) OUT		
Conformance with Approved Procedures			
29	IN OUT (N/A)		

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/20/24

Inspector (Signature) Michelle L Hoversos