



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

May 2, 2024

Licensee

Ridgeview Assisted Living, LLC

2020 Ridgeview Drive

International Falls, MN 56649

RE: Conditional License Number 412740
Health Facility Identification Number (HFID) 30482
Project Number(s) SL30482015

Dear Licensee:

On April 23, 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 January 1, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective **May 2, 2024**.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 23, 2024, survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 10, 2024, found not corrected at the time of the follow-up survey and/or subject to a penalty assessment are as follows:

1890-Prescription Drugs-144g.71 Subd. 20 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 23, 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 \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per 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:

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.

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.

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.

**Interim Assistant Division Director
Minnesota Department of Health
Health Regulation Division
PMB**

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649		
(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: SL30482015-1 On April 22, 2024, through April 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 January 10, 2024. At the time of the survey, there were 11 residents receiving services under the Assisted Living 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.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 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}			
{0 780} 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; This MN Requirement is not met as evidenced	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 2 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 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}			

Minnesota Department of Health

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{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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}			

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{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide complete specific resident instructions relating to the administration of medication for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), anxiety disorder, and Alzheimer's disease with late onset. R2's Service Plan Agreement dated March 18,	{01750}			

Minnesota Department of Health

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{01750}	Continued From page 5 2024, indicated R2 received the following services: insulin administration one-time daily, oral medications one to three times daily, and blood sugar (BS) checks daily. R2's medication administration record (MAR) dated April 1, 2024, through April 22, 2024, included: Lantus (long-acting insulin) 100 units/milliliter (ml) one time. Inject seven units subcutaneously (SQ) daily. HOLD if blood glucose (sugar) is less than 100, alternate injection sites every day. Two lines were on R2's MAR for R2's Lantus administration documentation: -A.M. (morning): initials of ULP who administered R2's Lantus -BS: documentation of BS reading. On April 23, 2024, at 7:29 a.m., the surveyor observed unlicensed personnel (ULP)-H use correct technique perform a BS check on R2's left middle finger to obtain a reading of 96. ULP-H checked R2's MAR and stated R2 would not require insulin this day. The surveyor and ULP-H reviewed R2's MAR. The surveyor asked ULP-H where she would have documented R2's insulin administration location. ULP-H stated there was a place to document R2's insulin administration site and pointed to a place on R2's MAR. The surveyor asked ULP-H the location R2's insulin had been administered the last time insulin had been required, to ensure an alternate site could be used. ULP-H stated she did not know where or how to find the information of where insulin had been administered previously. R2's prescriber's order dated January 30, 2024, included: -decrease Lantus to seven units SQ daily.	{01750}			

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{01750}	Continued From page 6 R2's MAR failed to include documentation of which SQ site had been used, to ensure ULP's alternated injection sites daily. On April 23, 2024, at 7:47 a.m., R2's MAR was reviewed with registered nurse (RN)-G. RN-G stated there was not a place for ULPs to follow the written directions, as to where document the site where Lantus was injected. RN-G confirmed location injection site was not being documented. The instructions for Lantus dated April 11, 2022, noted it is important to rotate injection sites to avoid lipohypertrophy, or an abnormal fat deposit under the skin. It's a common complication with daily insulin injections. The licensee's Medication & Treatment-Administration & Delegation policy reviewed March 4, 2024, noted when administration of medications was delegated or assigned to unlicensed personnel, the licensee would ensure that the registered nurse had: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the unlicensed personnel about the individual needs of the resident. In addition, the registered inures must instruct the unlicensed personnel of the complete procedure of checking a resident's medication administration record. No further information was provided.	{01750}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 7 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications for two of two residents (R4, 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) 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 22, 2024, at 10:12 a.m., the surveyor, registered nurse (RN)-F and RN-G reviewed the contents of the locked medication cart. RN-F and RN-G observed and confirmed the following: -R4's opened latanoprost 0.0005% (high eye pressure) eye solution had a label which indicated the eye solution had been opened March 26, 2024. The latanoprost eye solution did not indicate when the solution would expire. -R10's opened latanoprost 0.0005% eye solution had a label which indicated the eye solution had been opened April 8, 2024. The latanoprost eye solution did not indicate when the solution would expire.	{01890}			

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{01890}	Continued From page 8 On April 22, 2024, at 10:24 a.m., RN/consultant (RN/C)-G stated eye solution should be dated with an open date and an expiration date. RN-F moved a posting on a cork board positioned on the wall, behind the medication cart that noted medication (insulin) was good for 28 days once opened. RN-F confirmed R4 and R10's eye solution did not include an expiration date. On April 22, 2024, at 10:28 a.m., RN-F stated "we" (licensee) just put the expiration date on the eye drops (solution), adding the eye drops were good for six weeks once opened. RN-F confirmed different eye drops have different expiration dates. The manufacturer's instructions for latanoprost dated August 15, 2023, noted once opened the bottle can be kept at room temperature for six weeks. The licensee's Medications-Prescription Drugs & Prohibition policy reviewed March 20, 2024, noted, policy noted when the licensee received a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

February 5, 2024

Licensee

Ridgeview Assisted Living LLC
2020 Ridgeview Drive
International Falls, MN 56649

RE: Conditional License Number 412740
Health Facility Identification Number (HFID) 30482
Project Number(s) SL30482015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 10, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the 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 issuing a 90-day conditional license due to expire on **May 5, 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 \$3,000.00. **MDH is not imposing these fines against your license at this time.**

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

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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Ridgeview Assisted Living LLC a 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, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Ridgeview Assisted Living LLC is in substantial compliance.

The following conditions 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:** Ridgeview Assisted Living LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Ridgeview Assisted Living LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Ridgeview Assisted Living LLC 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
- c. **Consultant:** Ridgeview Assisted Living LLC will contract with an RN to provide consultation concerning all resident(s) to whom Ridgeview Assisted Living LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Ridgeview Assisted Living LLC. The consultant will 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 not have any affiliation with Ridgeview Assisted Living LLC and MDH must review the RN's credentials and approve the selection. Ridgeview Assisted Living LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Ridgeview Assisted Living LLC in an effort to help Ridgeview Assisted Living LLC 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. Ridgeview Assisted Living LLC 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 provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Ridgeview Assisted Living LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (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).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Ridgeview Assisted Living LLC to correct the violations cited during the survey as well as to determine the overall practice of Ridgeview Assisted Living LLC 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:** Ridgeview Assisted Living LLC will 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 Ridgeview Assisted Living LLC 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 Ridgeview Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Ridgeview Assisted Living LLC's assisted living facility license, and Ridgeview Assisted Living LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines Ridgeview Assisted Living LLC is not in substantial compliance, MDH may take additional enforcement action against Ridgeview Assisted Living LLC, 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.

Ridgeview Assisted Living LLC

February 5, 2024

Page 6

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Interim Assistant Division Director

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649			
(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: SL30482015 On January 8, 2024, through January 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were ten residents receiving services under the Assisted Living license. An immediate correction order was identified on January 9, 2024, issued for SL30482015, tag identification 2310. Immediacy remains for tag 2310, at a scope and level of I, as a plan of correction had not been recieved nor approved prior to survey exit on January 10, 2024.	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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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: During the entrance conference on January 8, 2024, at 10:21 a.m., LALD-A was the current LALD-A for the facility. On January 8, 2024, at 10:22 a.m., the evaluator reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD-A. The BELTSS website indicated LALD-A had his Assisted Living Director (effective November 5, 2021; expires October 31, 2024). The website did not indicate LALD-A as the Director of Record for the licensee, this section was left blank. LALD-A stated the BELTSS website had not been updated to identify him as the Director of Record. LALD-A stated he was	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 unaware this needed to be done. The licensee's Assisted Living Director policy dated May 23, 2023, noted the facility was required to have an Assisted Living Director licensed or permitted by the Board of Executives for Long Term Services and supports. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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;	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 (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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 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 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 January 8, 2024, at 10:29 a.m., licensed assisted living director/owner (LALD/O)-A and clinical nurse supervisor (CNS)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and 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, 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. - I have read and fully understand Minn. Stat.	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 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 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 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 or 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, 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. - 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 five was electronically signed by the owner on May 27, 2021. The licensee had an assisted living license, effective July 1, 2023, with an expiration date of June 30, 2024. The licensee failed to ensure the following	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 policies and procedures were developed and/or implemented: -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -infection control practices -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis (TB), consistent with current United States Centers for Disease Control and Prevention standards -medication and treatment management -delegation of tasks by registered nurses or licensed health professionals -supervision of unlicensed personnel performing delegated tasks. On January 10, 2024, at 11:42 a.m. to 12:12 p.m. during an interview with LALD/O-A and CNS-C they confirmed the licensee provided medication management services, followed infection control practices, provided training and competency evaluations of staff, and conducted staff screenings for TB but failed to implement the corresponding policies and procedures as required. As a result of this survey, the following orders were issued 0110, 0470, 0480, 0510, 0580, 0660, 0680, 0700, 0780, 0790, 0800, 0810, 1060, 1420, 1440, 1470, 1500, 1530, 1620, 1640, 1650, 1750, 1760, 1830, 1880, 1890, 1950, 1970, 2310, 2320, 2410, and 3090 indicating the licensee's	0 250			

Minnesota Department of Health

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0 250	Continued From page 8 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 (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470			

Minnesota Department of Health

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0 470	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels 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 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents The findings include: During the entrance conference on January 8, 2024, at 10:55 a.m., licensed assisted living director(LALD)-A and clinical nurse supervisor (CNS)-C stated the staffing pattern was: -days: one staff scheduled from 6:00 a.m. until 2:00 p.m., one staff scheduled at 7:00 a.m. until 3:00 p.m. -evenings: one staff scheduled from 2:00 p.m. until 10:00 p.m., one staff scheduled from 3:00 p.m. until 9:00 p.m. -nights: one staff scheduled. The facility's most current Staffing Plan/Staff Duties worksheet was dated October 2, 2023. The previous Staffing Plan/Staff Duties worksheet was dated February 14, 2023. The current resident roster dated January 8, 2024, included ten residents, four of the ten	0 470			

Minnesota Department of Health

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0 470	Continued From page 10 residents were admitted after October 2, 2023. R7 R7 was admitted on October 3, 2023. R7's diagnoses included hip replacement, right hip fracture, and dementia with behavioral disturbance. R7's Service Plan dated October 9, 2023, indicated R7 received services including bathing assistance, transfer assistance, toileting assistance, ambulation assistance, medication management, grooming and dressing assistance, safety checks and fall prevention, and orientation assistance. R7's Service Delivery Record dated January 1, 1024, through January 10, 2024, noted: -ambulation: physical assist two staff -bathing: physical assist two staff -bed mobility: physical assist two staff. On January 9, 2024, at 7:19 a.m., unlicensed personnel (ULP)-D stated R7 does not get up in the middle of the night "often." ULP-D added the sit to stand lift (mechanical lift/ device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) with two staff to assist would be used. ULP-D said currently R7 and possibly R3 would need assist with the sit to stand lift. On January 9, 2024, at 10:57 a.m., the surveyor observed ULP- D and ULP-E remove an abduction wedge (soft hip block with strap for separating knees after hip surgery) that had been placed between R7's legs and use a sit to stand lift to transfer R7 out of bed and onto a commode.	0 470			

Minnesota Department of Health

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0 470	Continued From page 11 R8 R8 was admitted on January 2, 2024. R8's diagnoses include diabetes, hypertension (HTN/high blood pressure), adjustment disorder, and major depressive disorder. R8's Service Plan dated January 12, 2024, indicated R8 received services including dressing and grooming assistance, bathing assistance, medication management, ambulation assistance and escorts. On January 8, 2024, at 1:02 p.m., the surveyor observed ULP-B assist R8 into a bathroom. ULP-B asked R8 to lean forward and grab onto that bar "there" motioning to a grab bar near the toilet. ULP-B stated, "I am going to take your pants down." ULP-B lowered R8's pants and assisted R8 to sit on the toilet. ULP-B asked R8 if she was "ready" and told R8 she was going to wipe her, and wipe her one more time, to make sure "you are good and clean." ULP-B assisted R8 off the toilet and into a wheelchair. R9 R9 was admitted on November 16, 2023. R9's diagnoses included subarachnoid hemorrhage (bleeding in the space that surrounds the brain/increasing pressure on the brain.) The Current Client Roster dated January 8, 2024, indicated R9 had recent hospitalization, falls in the past three months, required ADL (activities of daily living assistance,) medication reminders, stand by assist, laundry, housekeeping, and meal preparation.	0 470			

Minnesota Department of Health

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0 470	Continued From page 12 On January 9, 2024, at approximately 7:20 a.m., the surveyor observed R9 in bed with eyes closes, even and non-labored respirations. ULP-D stated R9 was one of the four resident's that used an alarm at the facility, adding it was not the floor matt type of alarm, rather a bed alarm. On January 9, 2024, at 8:32 a.m., LALD-A stated the staffing plan had not been updated since the facility had four new residents admitted to the facility. LALD-A stated he had thought about the need to review the staffing plan but had not got to it. The licensee held an assisted living facility licensed for a capacity of 12 residents and had a current census of ten residents. The licensee's Staffing & Scheduling policy dated May 23, 2023, noted the clinical nurse supervisor developed and implemented a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. In addition, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: -each resident's needs, as identified in the resident's service plan and assisted living contract -each resident's acuity level, as determined by the most recent assessment or individualized review -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises -staff experience, training, and competency.	0 470			

Minnesota Department of Health

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0 470	Continued From page 13 The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	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 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).	0 480			

Minnesota Department of Health

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0 480	Continued From page 14 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 9, 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			
0 510 SS=E	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 ensure infection control standards were followed for two of three employees (unlicensed personnel (ULP)-E, ULP-D) disinfecting shared equipment between resident use. 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	0 510			

Minnesota Department of Health

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0 510	Continued From page 15 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: SpO2 MONITOR On January 9, 2024, at 7:43 a.m., the surveyor observed ULP-E in the medication room looking for an SpO2 monitor (device used to monitor blood oxygenation percentage and pulse). ULP-E found the SpO2's case, however it was empty. ULP-E left the medication room and returned with an SpO2 monitor. The surveyor did not observe ULP-E clean/disinfect the SpO2 monitor prior to placing it on R2's finger to receive a reading of pulse 77, SpO2 96% room air. The surveyor did not observe ULP-E disinfect the SpO2 monitor after she removed it from R2's finger. On January 9, 2024, at approximately 8:00 a.m., ULP-E stated the SpO2 monitor was cleaned daily. ULP-E said she did not clean the SpO2 monitor prior to use on R2. ULP-E stated the SpO2 monitor was not cleaned before or after each use. TRANSFER BELT On January 9, 2024, at 9:56 a.m., the surveyor observed ULP-E pick up a transfer belt (a strap to help lift a person or assist a person with their gate) with had hand holders on the back side of it to transfer an unidentified resident. ULP-E stated the transfer belt belonged to R3. Directly after the above observation ULP-E stated "usually we use their own" transfer belt. ULP-E	0 510			

Minnesota Department of Health

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0 510	Continued From page 16 said the transfer belt should have been cleaned before use, and daily. On January 9, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-C stated each resident had their own transfer belt, but added if a transfer belt needed to be shared the transfer belt should be cleaned before and after use, "at least." SIT-TO-STAND LIFT On January 9, 2024, at 10:57 a.m., the surveyor observed ULP-E and ULP-D use a sit to stand lift (Joerns/ mechanical lift, device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) to assist R7 out of bed. The surveyor did not observe ULP-E or ULP-D clean the lift prior to or after use. ULP-E stated the lift got cleaned once a day, not between uses. ULP-D said the lift could be used on R7 and R3 and should be cleaned between use. ULP-D confirmed the lift had not been cleaned as required. On January 9, 2024, at 12:51 p.m., CNS-C stated the sit to stand lift should be cleaned when used from one room to another, and confirmed the lift could be used on two residents. On January 10, 2024, at 12:05 p.m., CNS-C confirmed reusable equipment was not cleaned as required. The Joerns Hoyer instructions Manual dated 2014 noted the manufacturer's recommends were to be carried out on a daily basis and before lift use, to include: clean with ordinary soap and water and/or any hard surface disinfectant. Harsh chemical cleaners or abrasives should be avoided as these may damage the surface finish	0 510			

Minnesota Department of Health

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0 510	Continued From page 17 of the lift. Avoid wetting any of the electrical parts. The licensee's Cleaning of Shared Medical Equipment policy dated May 23, 2023, noted in accordance with existing infection prevention and control policies and procedures, the facility implemented and maintained processes to ensure all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reuse. Common shared resident care equipment may include stethoscopes, glucometers not limited to individual resident use, mechanical lifts, etc. -all equipment must be cleaned immediately if visibly soiled, and immediately after use of residents with contact precautions (e.g. MRSA (methicillin-resistant staphylococcus aureus/ infection caused by a type of staph bacteria that's becomes resistant to many antibiotics,) VRE (vancomycin-resistant enterococcus/ antibiotic resistance occurs when the germs no longer respond to the antibiotics) , and C-Difficile (germ (bacterim) that causes diarrhea and colitis (inflammation of the colon) which is very contagious) regardless of cleaning schedule -items routinely shared, which cannot be cleaned between uses, will follow a regular schedule for cleaning and disinfection -cleaning and maintenance processes followed manufacturer's recommendations. -in the absence of recommendations, clean non-critical medication equipment surfaces with a mild detergent followed by cleaning with a disinfectant -follow product recommendations for disinfectants (how to apply, amount of the product must remain on the equipment, etc.) -use protective equipment such as gloves, goggles and gowns as needed.	0 510			

Minnesota Department of Health

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0 510	Continued From page 18 The licensee's Infection Control policy dated May 23, 2023, noted the facility's infection control program was consistent with current guidelines from CDS for prevention control in long-term care facilities, where applicable in assisted living facilities. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services.	0 580			

Minnesota Department of Health

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0 580	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 8, 2024, at 10:59 a.m., licensed assisted living director (LALD)-A stated the facility did not have any documentation of quality management activities. LALD-A stated he was aware the licensee was "supposed" to always have something going on, adding "that is on me." The licensee's Quality Management Project policy dated May 23, 2023, noted the facility would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 660 SS=D	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	0 660			

Minnesota Department of Health

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0 660	Continued From page 20 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included the completion of baseline TB screenings for one of three employees (unlicensed personnel (ULP)-E). In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test as required for one of three employees (ULP-E.) 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 facility's TB risk assessment was completed	0 660			

Minnesota Department of Health

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0 660	Continued From page 21 on October 2, 2023, and was determined to be a low risk level. On January 9, 2024, at 7:31 a.m., the surveyor observed ULP-E escort R2 into the medication room and administer R2's morning medication. ULP-E had a hire date of January 7, 2023, to provide direct care services to residents of the facility. ULP-E's employee record included a Baseline TB Screening for Health Care Workers (HCWs) form dated May 19, 2021. ULP-E's employee record did not include a completed Baseline TB Screening for HCW dated within 90 days of hire. ULP-E's employee record included a TB skin test form dated: -first step June 3, 2021, read June 5, 2021 -second step June 22, 2021, read June 24, 2021. ULP-E's employee record did not include an IGRA (serum blood test) or TST (first step) dated within 90 days of hire. On January 9, 2024, at 4:08 p.m., licensed assisted living director (LALD)-A stated he "honestly" thought the TB testing and screening was done within an acceptable time frame. LALD-A said ULP-E had been a previous employee. LALD-A said he was not aware of the 90-day requirement. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, screen (no symptoms of active TB	0 660			

Minnesota Department of Health

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0 660	Continued From page 22 disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The licensee's Tuberculosis Screening policy dated May 23, 2023, noted the facility established and maintained 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 (MMWR). Staff whose essential job functions require work within the same air space of home care clients (residents) were screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening were completed. Screening conducted as followed: -new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers) -new staff had an IGRA (interferon gamma release assay /blood test used to see whether a person had been exposed to TB blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. -no staff was permitted to begin work where the work involved sharing the air space with residents until the negative results of the first Mantoux were read and documented or a negative IGRA blood test result was received and documented -Staff TB screening results were kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 660			

Minnesota Department of Health

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0 660	Continued From page 23 (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 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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

Minnesota Department of Health

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0 680	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP updated March/April 2023, included a Hazard and Vulnerability Assessment (HVA), and instructions for staff to follow in case of a fire, severe weather, tornado, loss of power, bomb, water shortage, winter storm, and evacuation. The licensee's EPP did not include the following: -identification of the at-risk population needs like maintaining independence, communication, transportation, supervision, and medical care. On January 10, 2024, at 10:40 a.m., after a brief review of the components required in an EPP by the surveyor with licensed assisted living director(LALD)-A, LALD-A stated the facility's EPP did not identify at risk population and the EPP was incomplete. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated May 23, 2023, noted it was the intent the facility had in place an effective and compliant Emergency Preparedness Plan. The plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z-Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance."	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649		
(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
0 680	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to protect three of three resident's records (R2, R6, R3) against tampering. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with	0 700			

Minnesota Department of Health

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0 700	Continued From page 26 late onset, and pain in limbs. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received services including diabetes management (daily blood glucose monitoring and insulin administration), medication management, grooming, bathing, toileting assistance, and safety checks. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into the medication room, administer R2's morning medication and check R2's blood glucose level. R2's most current assessment was completed by clinical nurse supervisor (CNS)-C and was dated September 7, 2023. R6 R6's diagnoses included Alzheimer's disease with early onset, and restless legs syndrome (condition that causes an uncontrollable urge to move the legs.) R6's unsigned Service Plan dated January 8, 2024, indicated R6 received services including specialty diet preparation, medication management, grooming and bathing assistance, dressing assistance, and safety checks. On January 8, 2024, at approximately 2:00 p.m., the surveyor observed ULP-B administer 0.5 milligrams (mg) of risperidone (behaviors) in applesauce to R6. R6's most current assessment was completed by CNS-C and was dated July 16, 2023, and authenticated July 17, 2023.	0 700			

Minnesota Department of Health

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0 700	Continued From page 27 R3 R3's diagnoses include chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), and unspecified mental disorder due to known physiological condition. R3's Service Plan dated April 30, 2023, indicated R3 received services including medication management, ambulation assistance, safety checks, fall prevention, and orientation assistance. On January 9, 2024, at 5:49 a.m., the surveyor observed ULP-E and clinical nurse supervisor (CNS)-C assist R3 out of bed with aid of a transfer belt, and walker to ambulate to the bathroom. R3's most current assessment was completed by CNS-C and was dated October 6, 2023. On January 10, 2024, at 9:23 a.m., licensed assisted living director (LALD)-A stated CNS-C had been over-riding old assessments, when doing updates. LALD-A added the dates on the assessments stayed the same, even though the assessment information changed. LALD-A said he had just learned of this and would work with CNS-C on the on-line system used. The licensee's Resident Record-Information and Content policy dated May 23, 2023, noted all entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. In addition, resident	0 700			

Minnesota Department of Health

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0 700	Continued From page 28 records whether written or electronic would be protected against loss, tampering, or unauthorized discloser. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700			
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; This MN Requirement is not met as evidenced	0 780			

Minnesota Department of Health

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0 780	Continued From page 29 by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on January 9, 2024, at 11:00 a.m., with licensed assisted living director/owner (LALD/O)-A, LALD/O-A stated smoke alarms were not interconnected so activation of one alarm activates all alarms in the resident room next to the office in the front of the facility. LALD/O-A stated the smoke alarm in the resident room next to the office was added after the original existing smoke alarm system was installed and is not interconnected with the existing system. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. Smoke alarms are required to be maintained in accordance with manufactures instructions and replaced after 10 years of use. During the tour the LALD/O-A, verified the smoke alarm in the resident room next to the office is not interconnected so activation of one alarm	0 780			

Minnesota Department of Health

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0 780	Continued From page 30 activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Seven (7) 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; (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 provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 790			

Minnesota Department of Health

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0 790	Continued From page 31 The findings include: On a facility tour on January 9, 2024, at 11:30 a.m., with licensed assisted living director/owner (LALD/O)-A, it was observed the required fire extinguisher was installed at a height of 6 feet 6 inches above the floor to the top of the extinguisher. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on January 9, 2024, at 11:30 a.m., LALD/O-A, verified this required fire extinguisher was mounted above the required maximum of 5 feet from the floor to the top of the extinguisher. LALD/O-A stated the extinguisher will be moved to a location that allows it to be mounted not higher than 5 feet from the floor to the top of the extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) 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,	0 800			

Minnesota Department of Health

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0 800	Continued From page 32 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on January 9, 2024, at 11:30 a.m., with licensed assisted living director/owner (LALD/O)-A, the surveyor made the following observations of facility hazards and disrepair: The bottom sill of the window sash was rotten from moisture and weather elements and was detached from the window hardware of the emergency escape and rescue opening window in resident room #5. The emergency escape and rescue window opens freely when the latches are unlocked but the bottom rotten wooden sash was	0 800			

Minnesota Department of Health

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0 800	Continued From page 33 in need of repair. Storage was located under the enclosed porch in the back of the house that impeded the use of the emergency escape and rescue opening in resident room #4. The exterior path to the open yard from the emergency escape and rescue opening is required to be maintained at least 36 inches wide and 36 inches high for evacuation in the event of a fire or similar emergency. The lower portion of the wall was rotten from moisture around and next to the shower in the public/common bathroom in the lower level. Walls are required to be maintained in good repair and free from moisture damage. During a facility tour on January 9, 2024, at 11:45, LALD/O-A verified the above listed observations while accompanying on the tour. 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	0 810			

Minnesota Department of Health

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0 810	Continued From page 34 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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810			

Minnesota Department of Health

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0 810	Continued From page 35 The findings include: During observation on January 9, 2024, at 10:30 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants' accessibility. The plan was located in the sunroom of the lower level and not in the main hallways and, near the main front door and not in the common hallways and occupied spaces on the upper level. On January 9, 2024, at 10:30 a.m., licensed assisted living director/owner (LALD/O)-A 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 FSEP, failed to include the following: The number of resident sleeping rooms on the FSEP floor plan in order to identify the location of each room. The FSEP did not identify specific fire protection actions for residents evident by not including actions for residents in writing in the FSEP. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include individual unique needs of each resident for evacuation in writing and available for immediate use in the event of a fire or similar emergency.	0 810			

Minnesota Department of Health

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0 810	Continued From page 36 During an interview on January 9, 2024, at 10:30 a.m., LALD/O-Astated the residents were given direction verbally, but the resident procedures required during a fire or similar emergency are not documented in writing in the FSEP. LALD/O-A stated the unique needs of each individual resident for evacuation were not included in writing in the FSEP and available for immediate use in the event of a fire or similar emergency. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing written documentation indicating the training was offered to the residents one time annually. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by providing written documentation that employee training was provided only one time in 2023 in July. During an interview on January 9, 2024, at 10:30 a.m., LALD/O-A stated the training of employees and residents regarding procedures to take during fire or similar emergency are not documented in the required sequences. LALD/O-A stated resident training was completed verbally. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation that drills were conducted only two times in 2023 in March and September.	0 810			

Minnesota Department of Health

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0 810	Continued From page 37 During an interview on January 9, 2024, at 10:45 a.m., LALD/O-A stated a plan has been put into place to bring the facility into compliance with the documentation requirements for FSEP training of employees and residents and drills for employees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01060	Continued From page 38 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R7). 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:	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01060	Continued From page 39 R7's diagnoses include dementia with behavioral disturbances, and closed fracture of right hip. R7's Resident Incident Report dated December 30, 2023, noted, "called ambulance for transfer to hospital for further assessment." R7's record included an Interagency Referral Form dated January 4, 2024, which included discharge orders for R7's return to the facility. R7's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R7's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 8, 2024, at 11:45 a.m., licensed assisted living director (LALD)-A stated he was not aware of the requirement to notify OOLTC. LALD-A confirmed he had not completed the written notice as required for any resident.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01060	Continued From page 40 The licensee's Emergency Relocation policy dated May 23, 2023, noted the facility provided a written notice that contained, at a minimum: -the reason for the relocation -the name and contact information for the location to which the resident had been relocated and any new service provider -contact information for the Office of Ombudsman for Long-Term Care -if known and applicable, the approximate date or range of dates within which the resident was expected to rerun to the facility, or a statement that a return date was not currently known, and -a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The notice required would be delivered as soon as practicable to: -the resident, legal representative and designated representative -for residents who received home and community-based waiver services, the resident's case manger, and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility with four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 41 in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) ensured training and competency demonstration was completed for two of two unlicensed personnel (ULP-D, ULP-E), and additionally, the licensee failed to provide written instructions in the resident records for delegated tasks for two of two residents (R7, R2). Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated tasks provided by the unlicensed personnel (ULP) for one of one resident (R7) using mechanical lift (devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) and for one of one resident (R7) using abduction wedge (soft hip block with strap for separating knees after hip surgery). Further, the licensee failed to ensure written instructions for one of one resident using alarms (floor type) for R2. In addition, the licensee failed to ensure the RN ensured prior to	01420			

Minnesota Department of Health

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01420	Continued From page 42 the delegation of tasks ULPs were trained in the proper methods to perform the task and able to demonstrate competently for mechanical lifts for one of two (ULP-D) and abduction wedge for two of two (ULP-D, ULP-E). 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: MECHANICAL LIFT - ULP-D - R7 During the entrance conference on January 8, 2024, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the facility used two types of mechanical lifts: sit to stand (designed for users with some mobility and strength, needing some assistance) and "full body" lifts (lift sling/a sling placed under a person which is attached to an assisted device to assist a person with transfers.) R7's diagnoses include dementia with behavioral disturbances, and closed fracture of right hip. R7's Service Plan dated October 9, 2023, indicated R7 received services including bathing assistance, transfer assistance, toileting assistance, ambulation assistance, medication management, grooming and dressing assistance, safety checks and fall prevention, and orientation assistance.	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 43 R7's record lacked instructions related to use of mechanical lift. On January 9, 2024, at 7:25 a.m., ULP-D stated R7 and sometimes R3 would require use of a mechanical lift. ULP-D stated instructions were not in R7 or R3's records, when to use lift or which lift to use. On January 9, 2024, at 10:57 a.m., the surveyor observed R7 lying in bed. ULP- D and ULP-E pulled back the covers from R7 and removed an abduction wedge that had been placed between R7's legs and use a sit to stand lift to transfer R7 out of bed and onto a commode. On January 9, 2024, at 4:15 p.m., LALD-A stated R7's record did not include instructions for mechanical lift use. LALD-A and CNS-C said it made sense to have instructions in resident records. ULP-D's Assisted Living Training & Competencies Manual, Mechanical Lifts record dated October 2, 2023, included: "I attest that the employee listed below had successful completed this training evaluation, signed and authenticated by LALD-A. On January 10, 2024, at 2:23 p.m., LALD-A stated he did train for newer staff on mechanical lift, adding he was not aware the training needed to be done by RN. ABDUCTION WEDGE--ULP-D & ULP-E - R7 R7's Service Plan dated October 9, 2023, included: bed mobility: physical assist 2 -assist of two staff for turning and repositioning every two hours while in bed. HC (home care) staff to assist with turning & repositioning every	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 44 two hours while in bed. On January 9, 2024, at 11:00 a.m., ULP-E and ULP-D stated instructions for R7's abduction wedge, no 90-degree angle and pillow between legs while in chair were on a piece of paper they had been shown. ULP-E and ULP-D confirmed there were no instructions in R7's record for the abduction wedge. On January 10, 204, at 10:27 a.m., LALD-A stated CNS-C had done a nurse to nurse report for R7's hospital return and instructions, the "handwritten note" were from the nurse to nurse interview in CNS-C's hand writing. LALD-A and CNS-C confirmed R7's record did not include instructions for ULPs for abduction wedge. On January 9, 2024, at 11:00 a.m., ULP-E and ULP-D stated LALD-A and unidentified personnel (non-RN) did the training for R7's hospital return instructions. On January 9, 2024, at 12:57 p.m., LALD-A stated he and R7's husband trained ULPs for R7's hospital return instructions, to include R7's abduction wedge. FALL PREVENTION ALARMS - R2 R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with late onset, and pain in limbs. R2's unsigned Service Plan dated /printed January 8, 2024, included: -bed mobility: cueing/standby, unlicensed assistive personnel to provide cueing/standby when getting in and out of bed. -bed mobility: reminders, unlicensed assistive	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 45 personnel to provide reminders for resident to get in and out of bed -bed mobility: set-up, R2 does need assistance with covering himself up with blankets and freeing his feet when getting out of bed at times as well. Unlicensed assistive personnel to provide assistance pulling back covers, placing assistive equipment near bed), but resident is able to get in and out of bed independently -fall pad: place/ remove, R2 has a fall mat placed next to bed to help prevent falls as he frequently has failed in bedroom. Unlicensed assistive personnel to place all pad next to the bed at night and moved and store during the day. On January 9, 2024, at approximately 7:00 a.m., the surveyor observed R2 lying in bed and floor mats were positioned on both sides of R2's bed. ULP-D assisted R2 out of bed. On January 9, 2024, at 6:10 a.m., CNS-C stated she was "not quite sure" about the alarms, adding LALD-A had placed the alarms. CNS-C stated there was "probably" nothing in the resident's records about alarm and word of mouth might have been the mode of communication for alarms. CNS-C added she as not sure if staff were trained on alarm use. CNS-C asked the surveyor if she was responsible for alarms. On January 9, 2024, at approximately 7:00 a.m., ULP-D stated there were seven alarms in use at the facility. On January 9, 2024, at 8:26 a.m., LALD-A stated he was aware of the protocols, adding they (facility) had so many falls, and families were looking for solutions. LALD-A added the facility was trying to find "different things" to help reduce falls, within budget. LALD-A stated he spoke with	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 46 the families and families were in agreement of alarm use. The manufacturer's instructions for the Joerns lift dated 2014, noted daily task checklist included: -make sure the lift moves freely on its castors -examine the spreader bar is firmly attached to the boom -examine the sling hooks and attachment clips on the spreader bar and boom for excessive wear -make sure the legs open and close correctly -operate the hand control to confirm the boom raises and lowers satisfactorily -check the operation of the emergency stop button -examine slings for fraying or other damage. Do not use any sling if damaged -confirm the lift is not giving a low battery alarm when the hand control is operated. If the alarm sounds, do not use and place the battery on charge immediately. The licensee's Delegation of Assisted Living Services policy dated May 23, 2023, noted a registered nurse or licensed health professional at the facility may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. When the registered nurse or licensed health professional delegated tasks to unlicensed personnel, that person ensured that prior to the delegation the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's records.	01420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01420	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420			
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 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	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
01440	Continued From page 48 date on which the individual began working for the licensee and first performed delegated tasks for one of one unlicensed personnel (ULP-E). 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: ULP-E had a hire date of January 7, 2023, to provide direct care services to residents of the facility. On January 9, 2024, at 7:31 a.m., the surveyor observed ULP-E escort R2 into the medication room to check R2's blood glucose level and administer R2's morning medication. ULP-E's record did not include documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On January 9, 2024, at 12:41 p.m., licensed assisted living director (LALD)-A stated "we" (facility) are "now" completing 30-day staff supervisor visits, adding there is no documentation for any staff performing delegated tasks within 30 days of beginning work with the licensee. The licensee's Supervision of Staff-Delegated Services policy dated May 23, 2023, noted direct	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
01440	Continued From page 49 supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated tasks for residents and thereafter as needed based on performance. Documentation of supervisor activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470			

Minnesota Department of Health

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01470	Continued From page 50 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees, (unlicensed personnel (ULP)-E) employee record contained orientation to assisted living facility licensing to include all the required topics.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01470	Continued From page 51 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-E had a hire date of January 7, 2023, to provide direct care services to residents of the facility. On January 9, 2024, at 7:31 a.m., the surveyor observed ULP-E escort R2 into the medication room to check R2's blood glucose level and administer R2's morning medication. ULP-E's employee record included Guide to Assisted Living- Minnesota, dated August 9, 2021. ULP-E's employee record lacked evidence of completing the following assisted living orientation before providing assisted living services to the licensee's residents: -policies and procedures related to the provision of assisted living services by the individual staff person -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01470	Continued From page 52 On January 9, 2024, at 3:59 p.m., licensed assisted living director (LALD)-A said the Guide to Assisted Living completed August 9, 2021, was from past employment at the facility and ULP-E's record did not indicate the class had been repeated with this employment. LALD-A said ULP-E's record did not contain evidence required orientation was completed as required. The licensee's Staffing Requirement-Licensed Nurse and ULP policy dated December 12, 2022, noted unlicensed personnel providing assisted living services must have: -successfully completed a training and competency evaluation appropriate to the services provided by the facility and all required topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01500	Continued From page 53 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01500	Continued From page 54 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for three of three employees, (clinical nurse supervisor (CNS)-C, unlicensed personnel, (ULP)-B, ULP-D). 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: CNS-C CNS-C was hired on November 20, 2020, to oversee direct care staff and to provide direct care services to residents of the facility. On January 9, 2024, at 5:53 a.m., the surveyor observed CNS-C adjust a transfer belt on R3. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the facility's policies and procedures relating to the provision of assisted living services	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01500	Continued From page 55 and how to implement those policies and procedures -reporting maltreatment of vulnerable adults or minors -infection control techniques. On January 9, 2024, at 10:38 a.m., licensed assisted living director (LALD)-A stated CNS-C had not completed the required annual training. ULP-B ULP-B was hired on July 6, 2020, to provide direct care services to residents of the facility. On January 8, 2024, at 1:02 p.m., the surveyor observed ULP-B assist R8 into a bathroom. ULP-B's employee record lacked evidence ULP-B successfully completed annual training as required to include: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired on May 12, 2021, to provide direct care services to residents of the facility. On January 9, 2024, at 10:57 a.m., the surveyor observed ULP- D and ULP-E use a sit to stand lift (mechanical lift/ device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) to transfer R7 out of bed and onto a commode.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01500	Continued From page 56 ULP-D's employee record lacked evidence ULP-D successfully completed annual training as required to include: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 9, 2024, at 4:04 p.m., LALD-A confirmed ULP-B and ULP-D's records did not contain evidence of required training. The licensee's Annual Required Staff Training policy dated May 23, 2023, noted all staff that perform direct care services at the facility would complete at least eight hours of annual training for each 12 months of employment, and the training record would be kept in employee records, retained for each employee who performed direct home care services to track compliance with annual training requirement. The following training elements must be included every 12 months to all staff who performs direct care services: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques: the need for and use of protective gloves, gowns, and masks: appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades: disinfecting environmental surfaces; and	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01500	Continued From page 57 reporting communicable diseases -effective approaches to use to problem solve when working with a resident's challenging behaviors, ad how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01530	Continued From page 58 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three employees, (unlicensed personnel (ULP)-E) received the required amount of dementia care training in the required time frame. 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-E had a hire date of January 7, 2023, to provide direct care services to residents of the facility. On January 9, 2024, at 7:31 a.m., the surveyor observed ULP-E escort R2 into the medication room to check R2's blood glucose level and administer R2's morning medication. ULP-E's record included a total of 2.25 hours of	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01530	Continued From page 59 dementia training: -dementia-communication, overview, completed March 5, 2023, one hour -dementia-problem solving, overview, completed March 5, 2023, 0.75 hour -dementia-problem solving, sleep problems and sundowning, completed July 11, 2023, 0.5 hour. In addition, ULP-E's employee record included previous employment dementia training records, completed within 18 months of this employment. ULP-E's employee record did not include a total of eight hours of the required dementia training completed within 160 hours of the employee's start date. On January 9, 2024, at 3:58 p.m., licensed assisted living director (LALD)-A stated he printed out all ULP-E's training records, confirming the required dementia training had not been completed as required. LALD-A stated the requirement was not met within the time frame of 160 hours of employment. The licensee's Dementia Training policy dated May 23, 2023, noted direct care employees would complete eight hours of initial training within 160 hours of the employment start date. Employees may not provide direct care until the training was complete unless another employee who had completed the initial training was present to provide assistance. Required dementia training topics include: -an explanation of Alzheimer's disease and other dementia's -assistance with activities of daily living -problem solving with challenging behaviors -communication skills -person centered planning and service delivery.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01530	Continued From page 60 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
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 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 observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01620	Continued From page 61 reassessment using the uniform assessment tool by day 14-day for three of three residents (R2, R6, R3) and on day 90 for three of three residents (R2, R6, 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) 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: R2 R2 started receiving assisted living services by the licensee on March 15, 2021. R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with late onset, and pain in limbs. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received services including diabetes management (daily blood glucose monitoring and insulin administration), medication management, grooming, bathing, toileting assistance, and safety checks. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into the medication room, administer R2's morning medication and check R2's blood glucose level. R6 R6 started receiving assisted living services by	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
01620	Continued From page 62 the licensee on July 28, 2023. R6's diagnoses included Alzheimer's disease with early onset, and restless legs syndrome (condition that causes an uncontrollable urge to move the legs.) R6's unsigned Service Plan dated January 8, 2024, indicated R6 received services including specialty diet preparation, medication management, grooming and bathing assistance, dressing assistance, and safety checks. On January 8, 2024, at approximately 2:00 p.m., the surveyor observed ULP-B administer 0.5 milligrams (mg) of risperidone (behaviors) in applesauce to R6. R3 R3 started receiving assisted living services by the licensee on April 8, 2023. R3's diagnoses include chronic obstructive pulmonary disease (COPD/ a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), congested heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs), and unspecified mental disorder due to known physiological condition. R3's Service Plan dated April 30, 2023, indicated R3 received services including medication management, ambulation assistance, safety checks, fall prevention, and orientation assistance. On January 9, 2024, at 5:49 a.m., the surveyor observed ULP-E and clinical nurse supervisor (CNS)-C assist R3 out of bed with aid of a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
01620	Continued From page 63 transfer belt, and aid of a walker to ambulate to the bathroom. 14 DAY ASSESSMENTS On January 9, 2024, at 12:59 p.m., licensed assisted living director (LALD)-A stated the computer system currently used does not generate 14-day assessments. LALD-A confirmed 14-day assessments were not completed as required for R2, R6, R3. 90 DAY ASSESSMENTS R2 R2's most current assessment was completed by CNS-C and was dated September 7, 2023, (123 days from assessment to survey date.) R2's record lacked additional assessments available for review. R2's record lacked documentation the facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident. R6 R6's most current assessment (pre-assessment) was completed by CNS-C and dated July 16, 2023, (176 days from assessment to survey date.) R6's record lacked additional assessments available for review. R6's record lacked documentation the facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident. R3 R3's most current assessment was completed by CNS-C and dated October 6, 2023, (94 days from assessment to survey date.) R3's record lacked additional assessments available for review.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01620	Continued From page 64 R3's record lacked documentation the facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident. On January 10, 2024, at 9:23 a.m., LALD-A stated CNS-C had been over-riding old assessments, when doing updates. LALD-A added the dates on the assessments stayed the same, despite the assessment information changing. LALD-A said he had just learned of this and would work with CNS-C on the on-line system used. LALD-A confirmed the facility had not completed 90-day assessments as required. The licensee's Assessments, Reviews & Monitoring policy dated May 23, 2023, noted resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. 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	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01640	Continued From page 65 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 observation, interview, and record review, the licensee failed to ensure service plans were revised and authenticated to confirm agreement of the services to be provided for two of two residents (R2, R7). 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: During the entrance conference on January 8, 2024, at 10:40 a.m., regarding monitoring/assessments, licensed assisted living director (LALD)-A stated the clinical nurse	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01640	Continued From page 66 supervisor (CNS)-C completed the service plans based off assessments. R2 R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with late onset, and pain in limbs. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received services including diabetes management (daily blood glucose monitoring and insulin administration), medication management, grooming, bathing, toileting assistance, and safety checks. R2's Master Assessment dated March 27, 2023, included: -falls: resident has had a few falls over past three months -resident wears nonslip stockings at all times, nightly rounds are made for safety checks on R2. He (R2) has floor alarms on both sides of his bed. On January 9, 2024, at approximately 7:00 a.m., the surveyor observed R2 lying in bed and floor mats were positioned on both sides of R2's bed. The surveyor observed unlicensed personnel (ULP)-D assist R2 out of bed. On January 9, 2024, at 4:13 p.m., LALD-A stated R2's record did not include a signed service plan that had been updated to include R2's fall alarms. R7 R7's diagnoses include dementia with behavioral disturbances, and closed fracture of right hip. R7's Service Plan dated October 9, 2023, indicated R7 received services including bathing	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01640	Continued From page 67 assistance, transfer assistance, toileting assistance, ambulation assistance, medication management, grooming and dressing assistance, safety checks and fall prevention, and orientation assistance. On January 9, 2024, at 10:57 a.m., the surveyor observed R7 lying in bed. ULP-D and ULP-E pulled back the covers from R7 and removed an abduction wedge (soft hip block with strap for separating knees after hip surgery) that had been placed between R7's legs and use a sit to stand lift to transfer R7 out of bed and onto a commode. On January 9, 2024, at 12:49 p.m., LALD-A stated R7's service plan had not been updated as required. In addition, LALD-A said the facility had not been having new service plans signed with updates made as required. On January 10, 2024, at approximately 11:15 a.m., CNS-C stated R7 did not have any wound care services at the current time. CNS-C confirmed service plans were not updated as required. The licensee's Service Plan Modifications policy dated May 30, 2023, noted when a resident at the facility received assisted living services and a change (s) to the service plan occurred, the service plan must be amended in writing and signed by the resident or the resident's designated representative. If the service plan needed to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service plan Modification form would be completed: this form included: -describe changes in service and whether the service was added (new), changed, or discontinued	01640			

Minnesota Department of Health

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01640	Continued From page 68 -frequency of new service or if service if (sic) terminated -identification of the staff who would perform the service -schedule and methods of monitoring staff -fee for the service -date/signature of RN (registered nurse) making changes -date/signature of resident or the resident's representative each time a modification was made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. 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 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	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01650	Continued From page 69 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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, 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) 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: R2 R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with late onset, and pain in limbs. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received services including diabetes management (daily blood glucose monitoring and insulin administration), medication	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01650	Continued From page 70 management, grooming, bathing, toileting assistance, and safety checks. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into the medication room, administer R2's morning medication and check R2's blood glucose level. R2's Service Plan lacked: -methods of monitoring staff providing the services. R3 R3's diagnoses include chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), and unspecified mental disorder due to known physiological condition. R3's Service Plan dated April 30, 2023, indicated R3 received services including medication management, ambulation assistance, safety checks, fall prevention, and orientation assistance. On January 9, 2024, at 5:53 a.m., the surveyor observed clinical nurse supervisor (CNS)-C adjust a transfer belt on R3. R3's Service Plan lacked: -methods of monitoring staff providing the services. On January 9, 2024, at 1:00 p.m., the surveyor reviewed R2 and R3's Service Plans with licensed assisted living director (LALD)-A.	01650			

Minnesota Department of Health

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01650	Continued From page 71 LALD-A stated the service plans were missing methods of monitoring staff providing the services. LALD-A said the template was the same for all residents. The licensee's Service Plan Modifications policy dated May 30, 2023, noted service plans would include the schedule and methods of monitoring staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R2).	01750			

Minnesota Department of Health

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01750	Continued From page 72 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, Alzheimer's disease with late onset, and pain in limbs. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received insulin daily, and oral medication administration. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into the medication room and administer R2's pill form morning medications. R2's medication administration record (MAR) dated January 1, 2024, through January 7, 2024, included: -MiraLAX 17 grams/scoop powder, take 17 grams by mouth once daily. For constipation. R2's prescriber orders dated June 18, 2021, included: -MiraLAX (bowel health) 17 grams by mouth one time a day. Mix in 8 ounces of water, juice, soda, coffee, or tea prior to administration. On January 9, 2024, at 7:49 a.m., ULP-E stated she puts a cup full of MiraLAX into 8 ounces of	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01750	Continued From page 73 juice, adding she knows this is what she is to do because "I was told by RN." ULP-E confirmed R2's MAR did not include instructions for MiraLAX administration. On January 9, 2024, at 8:02 a.m., the surveyor observed ULP-E assist R2 to sit in a chair at the kitchen table. ULP-E mixed a cap full of MiraLAX she had placed into a plastic medication cup into a glass of juice and stirred the mixture. ULP-E stayed by R2's side until he had drunk the juice/medication mixture. On January 10, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-C confirmed R2's MAR did not contain instructions for MiraLAX. The licensee's Medications & Treatment-Administration & Delegation policy dated May 23, 2023, noted when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the facility would ensure that the registered nurse had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01760	Continued From page 74 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 the steps of the medication administration process was followed by one of two employees (unlicensed personnel/ULP-E). 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 January 9, 2024, at 6:44 a.m., the surveyor observed ULP-E remove seven medication cards from a locked medication cart and a bottle of Bayer aspirin for R3. ULP-E compared the medication on R3's electronic medication administration record and placed the medication into a medication cup. ULP-E took the medication cup to R3 who was seated at the dining room table and administered the medication to R3.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01760	Continued From page 75 ULP-E gathered plates from the table and went to speak to ULP-D. The surveyor did not observe ULP-E document R3's medication administration. On January 9, 2024, at 6:54 a.m., ULP-E stated documenting R3's medication, "slipped her mind." ULP-E added she normally documented medication administration right after medication administration. On January 9, 2024, at 9:57 a.m., clinical nurse supervisor (CNS)-C stated medication administration documentation should be done right after the medication was given. The licensee's Medication & Treatment-Administration & Delegation policy dated May 23, 2023, noted a registered nurse (RN) must instruct the ULP on the following medication administration tasks before delegating the task to them: -the complete procedure of checking a resident's medication administration record -the preparation of medication for administration -the administration of the medication to the resident -the documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medications or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01830	Continued From page 76	01830			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 8, 2024, at 10:41 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses include diabetes, hypertension (HTN/high blood pressure), short term memory loss, anxiety disorder, and Alzheimer's disease with late onset. R2's authenticated Service Plan dated March 31,	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01830	Continued From page 77 2021, indicated R2 received oral medication administration. R2's prescriber orders included the following medication and the dates the orders were signed: -atorvastatin calcium (high cholesterol) 20 milligrams (mg) daily, August 23, 2022 -glucophage (diabetes) 500 mg twice daily, March 30, 2021 -Lantus SoloStar (diabetes) 100 units/milliliter (ml) 13 units subcutaneously daily, HOLD if blood glucose is less than 100, March 30, 2021 -metoprolol tartrate (heart) 25 mg twice daily, HOLD if heart rate is below 60 beats per minute, August 23, 2022 -Miralax (bowel health) 17 grams/scoop, daily, August 23, 2022 -nameda (memory) 10 mg twice daily, August 23, 2022 -aspirin (heart health) 81 mg daily, August 23, 2022 -seroquel (anxiety) 25 mg daily, August 23, 2022 -ativan (anxiety) 0.5 mg at evening, August 23, 2022 -citalopram hydrobromide (antidepressant) 10 mg daily, August 23, 2022 -gabapentin (anticonvulsant) 100 mg three times daily, August 23, 2022 -metformin HCl (diabetes) 500 mg twice daily, August 23, 2022 R2's January 1, 2024, through January 7, 2024, medication administration record (MAR) listed medications as prescribed above, times to administer, and staff initials to indicate the medication had been given. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into the medication room and administer R2's	01830			

Minnesota Department of Health

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01830	Continued From page 78 morning medication. On January 10, 2024, at 11:21 a.m., CNS-C stated R2's record did not contain annual orders for R2's medication. CNS-C reviewed R4 and an unidentified resident's records and confirmed annual orders were lacking from their records also. The licensee's Medication & Treatment Orders-Renewal policy dated May 23, 2023, noted residents who received medication management services by the facility would have a current physician prescribed medication or treatment/therapy order on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=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. 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 into the locked medication room, for one of one medication room. In addition, the licensee failed to ensure medication	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649		
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01880	Continued From page 79 was stored according to manufacturer's recommendations for one of three residents (R5.) 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: SECURE MEDICATION STORAGE On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escorted R2 into a locked medication room and assisted R2 to sit in a chair. ULP-E unlocked the medication cart and stated she would first check R2's blood glucose level. ULP-E went to a drawer and removed a blood glucose meter. ULP-E looked for cotton balls in a drawer and was unable to locate any. ULP-E left the locked medication room with the medication cart unlocked with R2 and the surveyor in the room. On January 9, 2024, at 7:35 a.m., ULP-E stated she should have locked the medication cart when she left R2 and the surveyor in the locked medication room. On January 9, 2024, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated R2 or any resident should not be left alone in the medication room, adding that is "never allowed." The licensee's Medication Storage policy dated May 23, 2023, noted only authorized staff had	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01880	Continued From page 80 access to stored medications. MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS The Current Client Roster dated January 8, 2024, indicated R5 required medication reminders. On January 8, 2024, at 10:45 a.m., CNS-C stated the licensee provided medication administration, however, did not provide medication set up nor reminders. On January 8, 2024, at 11:32 a.m., during a review of the facility's medication refrigerator with CNS-C, CNS-C removed R5's opened latanoprost 0.005% (high eye pressure) eye solution from the medication refrigerator and placed the eye solution in R5's cubby. Directly after the above observation CNS-C stated R5's opened eye drops should be stored in the locked medication cart. The manufacturer's instructions for latanoprost dated February 20, 2023, noted once opened keep at room temperature. The licensee's Medication Storage policy dated May 23, 2023, noted medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01890	Continued From page 81 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications for three of three residents (R4, R5, R2) and the licensee failed to ensure medication was maintained bearing the original prescription label with legible information for one of one resident (R5.) 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 January 8, 2024, at 11:28 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C, including a review of the locked medication cart. CNS-C observed and confirmed the following: TIME SENSITIVE MEDICATION -R4's two opened latanoprost 0.0005% (high eye pressure) eye solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01890	Continued From page 82 -R4's opened timolol (high eye pressure) 0.5% ophthalmic solution did not have a label which indicated the date the eye solution was opened and when the solution would expire. -R5's opened latanoprost 0.0005% eye solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire. -R2's opened Lantus 100 units/milliliters (ml) (long-acting) insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire. On January 8, 2024, at 11:35 a.m., CNS-C stated eye solution should be dated with an open date and an expiration date. On January 8, 2024, at 12:04 p.m., CNS-C stated R2's Lantus had been opened on December 11, 2023, and had an expiration date of July 31, 2025. CNS-C said she did not know that Lantus had an expiration date once opened, adding "how come I don't know that." CNS-C stated R2 did not use Lantus daily adding R2's Lantus use was dependent on his daily blood glucose reading. ORIGINAL PRESCRIPTION LABEL On January 8, 2024, at 11:32 a.m., CNS-C moved a bottle of latanoprost eye solution from the medication refrigerator and placed the eye solution in R5's cubby. CNS-C stated R5's latanoprost eye solution should have a name on the bottle, adding "everyone knows who's it is." CNS-C looked in the medication cart for the box or bag for R5's latanoprost eye solution however she was unable to locate it. R5's latanoprost eye solution lacked original	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01890	Continued From page 83 prescription labels with information regarding the directions for use, medication dosage, resident's name, and the pharmacy in which it had been issued. The manufacturer's instructions for latanoprost dated February 20, 2023, directed to discard within 4 weeks of opening. The manufacturer's instructions for timolol dated March 20, 2020, directed to discard solution 28 days after opening the bottle. The manufacturer's instructions for Lantus insulin dated August, 2022, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Medication Storage policy dated May 23, 2023, noted medications would be stored consistent with manufacturer's recommendations and medications would be labeled as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649			
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01950	Continued From page 84 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R2) receiving blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, short-term memory loss, generalized anxiety disorder, delusional disorder, and late onset Alzheimer's disease with behavioral disturbance. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received diabetes information	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01950	Continued From page 85 (resident does not remember he is diabetic and often needs staff to explain as to why he is getting insulin. Observed for symptoms of high and low blood sugar, follow the directions on the medication administration record (MAR), insulin daily, oral medication administration, fasting blood sugar daily. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into a locked medication room and assist R2 to sit in a chair. ULP-E used correct technique to obtain R2's blood glucose reading of 112. R2's prescriber's order dated March 30, 2021, included: -glucose blood strips, check blood glucose every morning before breakfast. R2's medication administration record (MAR) dated January 1, 2024, through January 7, 2024, included: - a.m. (morning,) glucose blood STRP (strip), check blood glucose every morning before breakfast. R2's record lacked specific written instructions to include parameters for monitoring the blood glucose results. On January 9, 2024, at 7:49 a.m., ULP-E stated there were no instructions in R2's record for when to contact RN regarding R2's blood glucose reading. ULP-E said the only instructions in R2's record were when to administer R2's insulin. On January 10, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-C said specific instructions for ULPs to follow for blood glucose were not found in R2's record.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
01950	Continued From page 86 The licensee's Treatment & Therapy Management Plan policy dated May 23, 2023, noted each resident's record must contain documentation of specific resident instructions related to the treatments or therapy administration to include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R2) who received treatments managed by the provider. 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	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649			
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01970	Continued From page 87 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: During the entrance conference on January 8, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A stated the licensee provided treatment/therapy management services to the residents at the facility. R2's diagnoses included diabetes, short-term memory loss, generalized anxiety disorder, delusional disorder, and late onset Alzheimer's disease with behavioral disturbance. R2's authenticated Service Plan dated March 31, 2021, indicated R2 received diabetes management, including blood glucose monitoring. On January 9, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E escort R2 into a locked medication room and assist R2 to sit in a chair. ULP-E used correct technique to obtain R2's blood glucose reading of 112. R2's prescriber's order dated March 30, 2021, included: -glucose blood strips, check blood glucose every morning before breakfast. R2's medication administration record (MAR) dated January 1, 2024, through January 7, 2024, included: - a.m. (morning,) glucose blood STRP (strip),	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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01970	Continued From page 88 check blood glucose every morning before breakfast. On January 10, 2024, at 11:21 a.m., LALD-A and CNS-C stated they were not able to find a more current order for R2's blood glucose monitoring. CNS-C reviewed R4 and an unidentified resident's records and confirmed general annual orders were lacking from their records also. CNS-C added she "use to" renew all orders annually. The licensee's Medication & Treatment Orders-Renewal policy dated May 23, 2023, noted residents who received medication management services by the facility would have a current physician prescribed medication or treatment/therapy order on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
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 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	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
02310	Continued From page 89 services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R6) with hospital-style bed rails. In addition, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for one of one residents (R2) with an assistive device (consumer 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: This resulted in an immediate correction order on January 9, 2024. The findings include: HOSPITAL BED RAILS R6 On January 8, 2024, at 11:22 a.m., during a facility tour the surveyor observed a hospital bed (high-low scissor type/ fully adjustable bed with an expanded head, foot, and height adjustability. The bed moves up and down at the touch of a button on its remote control.) in R6's room. On January 8, 2024, at 11:48 a.m., licensed assisted living director (LALD)-A stated he was aware of the requirements for hospital bed rails. R6's diagnoses included Alzheimer's disease with	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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02310	Continued From page 90 early onset, and restless legs syndrome (condition that causes an uncontrollable urge to move the legs.) On January 8, 2024, at approximately 2:00 p.m., the surveyor observed unlicensed personnel (ULP)-B guide R6 to the medication room and place 0.5 milligrams (mg) of risperidone (antipsychotic medication used for behaviors/worked by changing the effects of chemicals in the brain), into a small amount of applesauce and administer the medication to R6. R6's assessment dated July 16, 2023, noted: -needed/received reminders for transfers: stand independently -needed/received verbal reminders for getting in and out of bed: able to get up independently -fall pad; used fall pad next to the bed, half bed rails; used bed rails for bed mobility. R6's record included a Side [Bed] Rail Use Assessment Form dated May 10, 2023, which noted: -side rails are indicated and serve as an enabler to promote independence -the client [resident] had expressed a desire to have side rails raised while in bed -the positive and negative aspects of side rail use have been discussed with the client and/or family, and the client (resident) and/or responsible parties are aware of the risks involved with side rail use. On January 8, 2024, at 2:36 p.m., LALD-A stated on January 6, 2024, the hospital bed was brought to the facility and he (LALD-A) assisted with the setup of R6's hospital bed. LALD-A stated no assessment had been done on this bed, adding R6's husband had the hospital bed at his home,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
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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
02310	Continued From page 91 and he wanted R6 to use the bed. LALD-A stated R6 was, "pretty good at getting into and out of bed but used the side rails for positioning." On January 8, 2024, at 3:58 p.m., LALD-A stated R6 had a "normal" bed with bed rails (consumer rails) prior to the hospital bed was set up on January 6, 2023. R6's record lacked a comprehensive assessment on the use of an assistive device to include measurements, risks and benefits of hospital bed, and to identify the intended purpose of the bedrails. On January 9, 2024, at 9:59 a.m., clinical nurse supervisor (CNS)-C measured R6's bedrail with surveyor present. The bedrail measured 7.25 inches tall by four inches wide, at the largest opening, which was in compliance with the FDA guidelines for bedrails. CONSUMER BEDRAIL R2 On January 9, 2024, at 7:01 a.m., the surveyor observed ULP-D assist R2 to move to the side of the bed and assist R2 out of bed. R2's bed had consumer type of bedrails on both upper sides of R2's bed. The side of the bed closest to the closet had a mesh type of covering over part of the bedrail, the over side of the bed did not have a mesh covering the bedrail and one was placed lower on the bed than the other bed rail. The surveyor did not observe R2 use the bedrail during the morning assist out of bed. R2's diagnoses included diabetes, short term memory loss, hypertension (HTN/high blood pressure,) anxiety disorder, delusional disorders, paranoia, and pain in limb.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649		
(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 92 R2's assessment dated March 27, 2023, noted: -resident has had a few falls over past three months. Along with some behavior exhibiting some anger -independent with toileting and/or continence care -fall risk/ high risk: resident wears non slip stocking at all times, nightly rounds are made for safety checks, he has floor alarms on both sides of his bed, staff also keeps close eye on him with transfers and wandering. R2's Side Rail Use Assessment Form dated May 10, 2023, noted: -side rails are indicated and serve as an enabler to promote independence -the client had expressed a desire to have side rails raised while in bed -the positive and negative aspects of side rail use had been discussed with the client and/or family, and the client and/or responsible parties are aware of the risks involved with side rail use. On January 9, 2024, at 8:38 a.m., LALD-A stated he would be more aware of what was in place for R2's bedrail than CNS-C. LALD-A said the facility did not check for recall of R2's bedrail, and the facility did not have the manufacturer's instructions for the bedrail. On January 9, 2024, at 10:01 a.m., the surveyor and CNS-C observed R2's consumer bedrails. The bedrail frames appeared to be two separate bedrail which were strapped under the mattress, two sets of straps. CNS-C stated R2's bedrails were "wobbly." R2's record lacked a comprehensive assessment for the use of an assisted device (bedrail,) including installation and use of the device	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30482	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2024
NAME OF PROVIDER OR SUPPLIER RIDGEVIEW ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 RIDGEVIEW DRIVE INTERNATIONAL FALLS, MN 56649			
(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 93 according to manufacturer's guidelines, lacked evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information The licensee's Side Rails policy dated May 23, 2023, noted when side rails were in use, registered nurse (RN) must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail was acting as a restraint, appropriate action should be taken. Staff from the facility would determine if the side rail was considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below.: -the side rail was used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. -the side rails were installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. -the side rail design was consistent with FDA (Food and Drug Administration) 2006 recommended dimensional measurements to reduce entrapment. The means side rail zones 1, 2, and 3 must not exceed 4.75 inches. The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided would be documented in the resident record. 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	02310			

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02310	Continued From page 94 FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310			

Minnesota Department of Health

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02310	Continued From page 95 interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE Immediacy of this order remained in place at the time of survey exit on January 10, 2024, and remained at a scope and level of level three, widespread (I).	02310			
02320 SS=D	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 observation, interview, and record review, the licensee failed to ensure insulin was administered per the manufacturer's instructions by one of two employees (unlicensed personnel/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320			

Minnesota Department of Health

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02320	Continued From page 96 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 January 9, 2024, at 7:52 a.m., the surveyor observed unlicensed personnel (ULP)-E check R2's blood glucose level using correct technique. R2's blood glucose reading was 112. ULP-E told R2 insulin was required. ULP-E removed R2's Lantus pen out of the medication cart. ULP-E cleaned the tip of the pen with alcohol pad and applied a needle to the pen. ULP-E double checked the MAR and primed the insulin pen with two units of insulin. ULP-E dialed the Lantus pen to 13 units and pinched an area on R2's right abdomen and injected the insulin. The surveyor did not observe ULP-E clean R2's abdomen site prior to insulin administration. Directly after the above observation ULP-E stated she does not clean insulin inject sites prior to insulin administration. On January 9, 2024, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-C stated she does not use alcohol to clean the skin prior to insulin administration. ULP-E's Medication Administration-Injections-Subcutaneous (SQ, Sub-Q) injection medication administration competency dated January 5, 2023, noted: -clean the pre-planned alternating injection site (see MAR) with alcohol wipe or soap and water. If	02320			

Minnesota Department of Health

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02320	Continued From page 97 using the abdomen, remain four inches away from the navel (belly button.) On January 9, 2024, at 12:53 p.m., CNS-C stated if ULP-E was taught to clean site with alcohol prior to insulin administration that would be her expectation. CNS-C confirmed ULP-E should have cleaned the site prior to R2's insulin administration. The manufacturer's instructions for Lantus dated August 2022, noted: -select the dose -inject the dose: clean site with an alcohol swab. Keep the pen straight, insert the needle into skin. The licensee's Delegation of Assisted Living Services policy dated May 23, 2023, noted a registered nurse or licensed health professional at the facility may delegate task only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. Performing routine delegated medical or nurse procedures such as insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and	02410			

Minnesota Department of Health

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02410	Continued From page 98 seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for two of four residents (R8, R7) observed during personal 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 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:	02410			

Minnesota Department of Health

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02410	Continued From page 99 R8 R8's diagnoses include diabetes, hypertension (HTN/high blood pressure), adjustment disorder, and major depressive disorder. R8's Service Plan dated January 12, 2024, indicated R8 received technology assist, bathing assist, escorts, dressing assist, grooming, nail care, denture assist, safety checks, medication administration, ambulation assist, bed mobility assist, skin monitoring, pain management, bed making, housekeeping, laundry, and vital sign monitoring. On January 8, 2024, at 1:02 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R8 into a bathroom. ULP-B did not close the bathroom door. ULP-B told R8 to lean forward and grab onto that bar "there" motioning to a grab bar near the toilet. ULP-B stated, "I am going to take your pants down." ULP-B lowered R8's pants and assisted R8 to sit on the toilet. ULP-B stated yes, this was the "normal routine." ULP-B asked R8 if she was "ready" and told R8 she was going to wipe her, and wipe her one more time, to make sure "you are good and clean." ULP-B assisted R8 off the toilet and into a wheelchair. On January 8, 2024, at 1:12 p.m., ULP-B stated she should have closed the bathroom door when she assisted R8. ULP-B added if anyone would have been in the area, she would have closed the door. ULP-B confirmed others could have walked by the open door while she was assisted R8. On January 8, 2024, at 2:33 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C both stated they "would hope" ULPs are closing doors when personal cares are being provided.	02410			

Minnesota Department of Health

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02410	Continued From page 100 R7 R7's diagnoses include dementia with behavioral disturbances, and closed fracture of right hip. R7's Service Plan Agreement dated October 9, 2023, indicated R7 received elopement risk evaluation, activity assist, telephone assist, bathing assist, orientation assist/severe confusion, dining escort and assist, dressing and undressing assist, oral care, nail care, bed mobility assist, medication administration, transfer assist, grooming assist, safety checks, fall pad placement and removal, toileting assist, pain management, skin monitoring, wound monitoring, bed making, laundry, housekeeping, and vital sign monitoring. On January 9, 2024, at 10:57 a.m., the surveyor observed R7 lying in R7's bed. ULP- D and ULP-E pulled back the covers from R7 and removed an abduction wedge (soft hip block with strap for separating knees after hip surgery) that was placed between R7's leg. ULP-D and ULP-E used a sit to stand lift (mechanical lift/ device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) to transfer R7 out of bed and onto a commode. R7's door or curtain had not been closed and R7's commode was in direct view of R7's door. Directly after the above observation ULP-E stated R7's door or curtain should have been closed. ULP-E closed a curtain that was in front of R7's door to provide privacy to R7 while on the commode. On January 10, 2024, at 12:17 p.m., CNS-C	02410			

Minnesota Department of Health

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02410	Continued From page 101 stated there was "no excuse" of staff not providing privacy, closing doors when providing personal cares. The licensee's Toileting Assistance policy dated May 23, 2023, noted personnel was to either stay with resident while on toilet or close the unlocked bathroom door per resident preference. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all ten residents,	03090			

Minnesota Department of Health

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03090	Continued From page 102 staff, and visitors of the licensee. 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). Findings include: On January 8, 2024, at 10:15 a.m., the surveyor entered the facility and observed a sign posted on the front of the facility that noted, "WARNING Protected By 24 HOUR VIDEO SURVEILLANCE," CCTV (closed circuit television/a system in which signals are not publicly distributed but are monitored, primarily for surveillance and security) Security Pros, a security camera solutions company." The sign included a contact number for the security company. In addition, there was another sign that noted "WARNING Audio and Video Surveillance on Duty At all Times, CCTV Security Pros, a security camera solutions company" with contact number. On January 8, 2024, at 11:13 a.m., licensed assisted living director (LALD)-A and the surveyor toured the facility. LALD-A stated the only signage posted regarding electronic monitoring was the signage mentioned above. LALD-A stated the facility had "maybe" 12 cameras with CCTV feed, adding the cameras were only in the common's areas, not in any of the bedrooms. On January 8, 2024, at 11:17 a.m., LALD-A confirmed the facility did not have the required	03090			

Minnesota Department of Health

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03090	Continued From page 103 electronic monitoring signage. The licensee's Electronic Monitoring policy dated May 23, 2023, noted signs were installed at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			

Type: Full
Date: 01/09/24
Time: 08:24:51
Report: 1019241002

Food and Beverage Establishment Inspection Report

Page 1

Location:

Ridgeview Assisted Living Llc
2020 Ridgeview Drive
International Falls, MN56649
Koochiching County, 36

Establishment Info:

ID #: 0038987
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182832806
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

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

OBSERVED ESTABLISHMENT HAS NO WAY TO TEST THE SURFACE CONTACT TEMP OF THE SANITIZING CYCLE OF THE HOT WATER DISH MACHINE

CORRECTION: OBTAIN EITHER WATERPROOF HIGH TEMP RECORDING THERMOMETER OR WAX TEST STRIPS THAT RECORD 160 F. TEST WEEKLY.

LEFT WAX ST

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

OBSERVED NO QUAT. AMMONIA TEST KIT PRESENT FOR WIPING CLOTH DISPENSER.

CORRECTION: GET QUAT. TEST STRIPS.

LEFT TEST STRIPS ON SITE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

OBSERVED ESTABLISHMENT DOES NOT HAVE A CFPM ON STAFF

CORRECTION: HAVE EMPLOYEE OBTAIN CFPM LICENSE.

Comply By: 03/29/24

Type: Full
Date: 01/09/24
Time: 08:24:51
Report: 1019241002
Ridgeview Assisted Living Llc

Food and Beverage Establishment Inspection Report

Page 2

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 F Degrees Fahrenheit - Location: FRIDGE - PICKLES
Violation Issued: No

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

DISCUSSION:
MENU,
PREP WORK,
HOT WATER DISH MACHINE,
REFRIGERATION NEEDS,

NO CHILL/REHEAT FOOD PREP IS ALLOWED BEFORE SERVICE. ESTABLISHMENT DOES NOT HAVE EQUIPMENT TO COMPLETE SAFELY.

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 1019241002 of 01/09/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Establishment Representative

Signed: _____

Jared Morrill
Sanitarian
Bemidji
218 308-2128