Electronically Delivered

March 17, 2023

Licensee
Ridgeview Senior Living
1009 10th Avenue Northeast
Sauk Rapids, MN 56379

RE: Project Number(s) SL20619015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

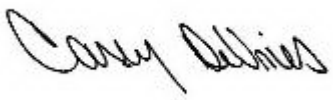
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations 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: SL20619015-0 On February 13, 2023, through February 17, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 47 residents, 42 of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on February 14, 2023, issued for SL20619015-0, tag identification 2310. On February 15, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I. An immediate correction order was identified on February 16, 2023, issued for SL20619015-0, tag identification 1290.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On February 17, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope and level of G.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 13, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 2 (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for one of one resident (R4). This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 485		

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0 485	Continued From page 3	0 485		

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 February 13, 2023, at 9:33 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated the licensee provided three meals a day to the residents, and stated residents could either choose the meal plan with three meals, seven days per week, or they could choose to opt out and not receive any meals at all. LALD-B stated, "Everyone is enrolled, it's all or nothing."

On February 13, 2023, at 12:05 p.m., LALD-B provided a "survey binder" that included a blank, undated, Assisted Living Contract, identified as the licensee's assisted living with dementia care contract, and LALD-B indicated the documents in the binder were current.

The Assisted Living Contract, page 5 of 20, section III. Housing, 1. Housing Related Services Included In The Monthly Rent, indicated the licensee included all basic housing services or amenities identified below in the monthly rent, and listed under "b. Availability of three (3) nutritious meals per day." The contract lacked an option for residents to opt out of payment for meals residents would not want.

R4 was admitted September 1, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R4 also received hospice services.

R4's Assisted Living Contract, dated August 1,

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0 485	Continued From page 4 2021, was signed by R4 on July 30, 2021, and included the above contract language regarding meals. The contract also included a Meal/Food Plan Addendum, signed by R4 on October 10, 2022, which indicated entering into a Meal/Food Plan with the licensee was entirely optional and was not required to become and/or remain a resident of the facility. The plan had two check boxes, directing the resident to check either "Three (3) meals each day for [blank] per month," or "No meal plan through Ridgeview Place." R4 checked the box indicating "Three (3) meals each day for 0 per month." R4's Amendment to Addendum A, dated April 14, 2022, and signed by R4 on August 15, 2022, identified as the service plan, indicated R4 received services including escort services to remind and escort to meals, medication administration, oxygen management, daily safety checks, toileting assistance, housekeeping, and laundry. R4's Master Assessment-Condensed, dated February 9, 2023, identified as the 90 Day Assessment, indicated R4 had no reported or observed concerns affecting intake, regular diet with regular texture, was independent with meals and was independent with coming to meals. R4's Nursing Assessment, dated February 9, 2023, identified as the annual assessment, indicated R4 was on hospice and appetite had declined, was a very picky eater and ate mostly sweets and Ensure (nutritional drink), and noted "Will eat 1 meal prepared by facility." On February 13, 2023, at 3:30 p.m., the evaluator accompanied clinical nurse supervisor (CNS)-A to visit R4 in his apartment. R4 was transferring	0 485		

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0 485	Continued From page 5 himself into the wheelchair after using the restroom. R4 was alert, talkative, and discussed how uncomfortable his current bed and mattress were. On February 16, 2023, at 11:23 a.m., CNS-A stated although R4 had signed his contract indicating he chose and was paying for the three meal per day option, he ate only one hamburger per day. CNS-A stated, "It's all or nothing," and indicated there was no option to opt out of the meals that a resident did not want. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650		

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0 650	Continued From page 6 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee records contained the required content for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A was hired to provide direct care and assisted living services on March 8, 2022. On February 13, 2023, at 3:30 p.m., the evaluator accompanied CNS-A to visit R4 in his apartment. R4 was transferring himself into the wheelchair after using the restroom. R4 was alert, talkative, and discussed how uncomfortable his current bed and mattress were. CNS-A's employee record lacked evidence of: - a current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 7 staff persons providing supervision; - records of review of the provider's policies and procedures, handling of complaints, and a review of the types of services the employee would provide and the provider's scope of license. ULP-E ULP-E was hired to provide direct care and assisted living services on January 5, 2023. On February 13, 2023, at 1:06 p.m., the evaluator observed ULP-E bring R1 to her apartment and assist her to get into bed. ULP-E's employee record lacked evidence of: - records of review of the provider's policies and procedures, handling of complaints, and a review of the types of services the employee would provide and the provider's scope of license; and - records of training and competency (when required) to include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the provider; - maintenance of a clean and safe environment; - care and use of hearing aids; - dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	0 650		

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0 650	Continued From page 8 cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-F ULP-F was hired to provide direct care and assisted living services on July 21, 2021. On February 15, 2023, at 9:27 a.m., the evaluator and ULP-F entered R3's apartment. The evaluator observed while ULP-F demonstrated the process of glucose monitoring for R3. R3 was sitting on her sofa in her apartment with her eyes closed initially, but did awaken and visited briefly with ULP-F. ULP-F's employee record lacked evidence of: - a review of the types of services the employee would provide and the provider's scope of license. On February 17, 2023, at approximately 8:25 a.m., CNS-A stated she provided the orientation upon hire and said the training was not documented in the employees' files as required. CNS-A stated she was not aware of why it was not included. CNS-A stated ULP-F's training and competency testing was completed as required and she personally completed the checklist. However, she was unable to locate the checklist with the documented evidence.	0 650		

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0 650	Continued From page 9 The licensee's Orientation for Assisted Living Staff policy dated effective August 1, 2021, noted the licensee would retain evidence in the employee records of the staff who had completed the orientation and training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention	0 660		

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0 660	Continued From page 10 (CDC) including evidence of a two-stop tuberculin skin test (TST) or other evidence of TB screening such as blood test for one of three employees (clinical nurse supervisor (CNS)-A). 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: During the entrance conference on February 13, 2023, at 9:20 a.m., with CNS-A and licensed assisted living director (LALD)-B, the evaluator requested to review the facility TB risk assessment. The licensee's facility TB risk assessment dated July 25, 2022, noted the TB risk level of the facility was "low". CNS-A was hired to provide direct care and assisted living services on March 8, 2022. Throughout the survey from February 13, 2023, through February 17, 2023, the evaulator observed CNS-A throughout the facility interacting with residents. CNS-A's employee record contained a history and symptom screening dated March 8, 2022. It also contained a negative QuantiFERONTB Gold test dated collected March 23, 2022.	0 660		

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RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 On February 17, 2023, at 8:25 a.m., CNS-A stated she started at only working one day per week doing orientation, and was not able to state when she first was in contact with residents. However, she stated it was before March 23, 2022, and was not sure why it had not been completed as required. The licensee's TB Infection Control Plan dated revised August 2021 noted the employee may only begin direct care after a negative blood test or 1st step tuberculin skin test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 12 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 observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. 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 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).	0 680		

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0 680	Continued From page 13 The findings include: On February 16, 2023, at 12:58 p.m., licensed assisted living director (LALD)-B provided a white binder titled Emergency Plan Book. The licensee's plan lacked the following required content: - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; and - EP testing/annual testing requirements. On February 17, 2023, at 9:25 a.m., LALD-B and maintenance supervisor (MS)-H stated the EP plan was last updated in October 2022 and staff were trained on the EP plan at that time, however, LALD-B stated there was no documentation of any drills or testing specific to the EP plan. LALD-B and MS-H were unable to find in their communication plan, a means to providing information about their occupancy, needs, and their ability to provide assistance, as required. The licensee's Emergency Operation Plan (EOP) Policies and Procedures, undated, directed the facility used an "all-hazards" approach for emergency planning and response, and indicated this was accomplished through practiced teamwork, effective communication, and the process of incident action planning. The policy indicated unoccupied beds, spare mattresses, and blankets were available to shelter others needing assistance; however, lacked a means to providing information about their occupancy, needs, and their ability to provide assistance. In addition, the policy included, "A Training and Testing Plan was developed and is maintained."	0 680		

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0 680	Continued From page 14 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730		

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0 730	Continued From page 15 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of all provided services was completed for four of four residents (R1, R2, R3, and R4). In addition, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged 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: DOCUMENTATION OF PROVIDED SERVICES	0 730		

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0 730	Continued From page 16 R1 R1's diagnoses included cognitive decline, type 2 diabetes mellitus, and hypertension (high blood pressure). R1's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated August 17, 2022, indicated R1 required services including monthly wellness checks, medication administration, bathing, escort assistance, safety checks, toileting, grooming, dressing, transfer assistance, daily weight, housekeeping, and laundry. On February 13, 2023, at 1:06 p.m., the evaluator observed unlicensed personnel (ULP)-E assist R1 back to her room from the dining room. R1 stated she wanted to get in bed to rest, so ULP-E assisted her to stand and walk to bed. The evaluator observed R1 grab the device on the right side of her full-sized bed with her right hand and then sit down. ULP-E assisted R1 to raise her feet onto the bed and to reposition to the middle of the bed. R1 held the device the whole time. R1's Service Checkoff List for February 2023 listed services, times to provide, and staff initials to indicate the medications had been given; however, the checkoff list lacked documentation to indicate the following services had been provided: - February 5, 2023, at 2:00 a.m., medication administration; - February 5, 2023, at 3:00 a.m., toileting/incontinence assist; - February 5, 2023, and February 6, 2023, at 6:00 a.m., toileting/incontinence assist; - February 6, 2023, at 7:50 a.m., escort assist; - February 6, 2023, at 9:00 a.m., grooming;	0 730		

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0 730	Continued From page 17 - February 6, 2023, at 9:00 a.m., toileting/incontinence assist; - February 2, 2023, and February 9, 2023, at 10:00 a.m., housekeeping; - February 6, 2023, at 10:00 a.m., safety checks; - February 6, 2023, at 11:00 a.m., check pendant; - February 6, 2023, at 11:50 a.m., escort assist; - February 6, 2023, at 12:00 p.m., toileting/incontinence assist; - February 7, 2023, at 8:00 p.m., medication administration; and - February 10, 2023, and February 11, 2023, at 10:00 p.m., toileting/incontinence assist. R2 R2's diagnoses included dementia with behavioral disturbances and hypertension (high blood pressure). R2's Amendment to Addendum A (Section IV-2) identified as the service plan, dated January 18, 2023, noted services including medication administration, grooming, dressing, and toileting. R2's Service Checkoff List for February 2023 listed services, times to provide, and staff initials to indicate the medications had been given; however, the checkoff list lacked documentation to indicate the following services had been provided: - February 5, 2023, and February 6, 2023, at 6:00 a.m., behavior monitoring; - February 6, 2023, at 7:00 a.m., dressing; - February 6, 2023, at 7:00 a.m., grooming; - February 6, 2023, at 7:00 a.m., toileting/incontinence assist; - February 6, 2023, at 8:00 a.m., escort assist; - February 6, 2023, at 8:00 a.m., medical monitoring; - February 6, 2023, at 9:00 a.m.,	0 730		

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0 730	Continued From page 18 toileting/incontinence assist; - February 7, 2023, at 10:00 a.m., housekeeping; - February 6, 2023, at 11:00 a.m., toileting/incontinence assist; - February 6, 2023, at 12:00 p.m., escort assist; - February 6, 2023, at 1:00 p.m., toileting/incontinence assist; - February 6, 2023, at 2:00 p.m., behavior monitoring; - February 7, 2023, at 5:00 p.m., medication administration; - February 10, 2023, at 8:00 p.m., dressing; - February 10, 2023, at 9:00 p.m., toileting/incontinence assist; and - February 10, 2023, at 10:00 behavior monitoring. R3 R3's diagnoses included diabetes, insomnia (inability to sleep), dementia, and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). R3's Amendment to Addendum A, identified by LALD-B as the service plan, signed April 21, 2022, indicated R3 required services including monthly wellness checks, medication administration, blood sugar monitoring, housekeeping, and laundry. On February 15, 2023, at 9:27 a.m., the evaluator and ULP-F entered R3's apartment. The evaluator observed while ULP-F demonstrated the process of glucose monitoring for R3. R3 was sitting on her sofa in her apartment with her eyes closed initially, but did awaken and visited briefly with ULP-F. R3's Service Checkoff List for February 2023, listed services, times to provide, and staff initials	0 730		

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0 730	Continued From page 19 to indicate the services had been provided; however, the checkoff list lacked documentation to indicate the following services had been provided: - February 2, 2023, and February 9, 2023, at 10:00 a.m., housekeeping services; - February 4, 2023, at 8:00 a.m., TEDS (compression stockings) on/off; and - February 10, 2023, and February 12, 2023, at 8:00 a.m., medication assist/administration and other duties (ensuring resident's safety). R4 R4's diagnoses included chronic obstructive pulmonary disease, ataxia (poor muscle control that causes clumsy voluntary movements, causing difficulty with walking and balance), spinal stenosis lower back (space inside the backbone is too small causing pressure on spinal cord and nerves), anxiety, and polyneuropathy. R4's Amendment to Addendum A, identified by LALD-B as the service plan, dated April 14, 2022, and signed by R4 on August 15, 2022, indicated R4 received services including escort services to remind and escort to meals, medication administration, control drug count, oxygen management, daily safety checks, toileting/incontinence assistance, housekeeping, and laundry. On February 13, 2023, at 3:30 p.m., the evaluator accompanied clinical nurse supervisor (CNS)-A to visit R4 in his apartment. R4 was transferring himself into the wheelchair after using the restroom. R4 was alert, talkative, and discussed how uncomfortable his current bed and mattress were. R4's Service Checkoff List for February 2023,	0 730		

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0 730	Continued From page 20 listed services, times to provide, and staff initials to indicate the services had been provided; however, the checkoff list lacked documentation to indicate the following services had been provided: - February 3, 2023, at 9:00 a.m., toileting/incontinence assistance; - February 6, 2023, at 10:30 a.m., injection; - February 10, 2023, and February 12, 2023, at 6:30 a.m., control drug count; - February 10, 2023, and February 12, 2023, at 8:00 a.m., other duties (ensuring resident's safety); and - February 10, 2023, and February 12, 2023, at 9:00 a.m., medication assist/administration. On February 16, 2023, at approximately 9:10 a.m., CNS-A stated there were areas on the checkoff list missing initials and stated staff were expected to sign off after each service was provided, and if it was not provided, to document the reason it was not provided. CNS-A stated she was under the impression the electronic system would not allow staff to complete their documentation for the day without having all areas signed off, so she would have to check into it. DISCHARGE SUMMARY R5 R5's record lacked a discharge summary to include: - diagnoses; - allergies; - treatments and therapies; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental and behavioral status.	0 730		

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0 730	Continued From page 21 R5 was admitted to the licensee on March 9, 2021, with diagnoses including epilepsy, cyst of kidney, gastroesophageal reflux, dependence on supplemental oxygen, type 2 diabetes with diabetic ophthalmic (eyes) complication, chronic kidney disease, depression, and insomnia (inability to sleep). R5 was discharged on January 31, 2023, to a different facility. R5's Discharge Summary, dated January 31, 2023, indicated R5 had a sore ankle and was requiring assistance of two to three staff and the licensee was unable to meet R5's needs. After discussion with guardian and with their permission for evaluation, R5 was sent to the emergency department on January 19, 2023, via emergency medical services. R5's family came to the facility "a few days later" and moved all of his belongings out of the facility, demanded his medications, and would not inform the licensee of what was happening with R5's care. The hospital notified the licensee that R5 had been discharged to a different facility. On February 16, 2023, at 10:34 a.m., clinical nurse supervisor (CNS)-A stated R5's discharge summary did not include all of the required contents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 810		

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0 810	Continued From page 22 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the	0 810		

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0 810	Continued From page 23 potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on February 15, 2023, at approximately 10:15 a.m. with Maintenance Staff (MS)-H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use R.A.C.E. acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, MS-H verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, MS-H verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation	0 810		

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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
0 810	Continued From page 24 indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, MS-H verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, MS-H stated the licensee did not have any documented training or a policy on training employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, MS-H stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated one evacuation drill had been completed on April 28, 2022. All other evacuation drills had been completed in October 2022 and January 2023.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	02/17/2023

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0 810	Continued From page 25 During interview, MS-H verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=E	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 26 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for two of four residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee began providing services under their assisted living facility with dementia care license on August 1, 2021. On February 13, 2023, at 12:05 p.m., LALD-B provided a "survey binder" that included a blank, undated, Assisted Living Contract, identified as the licensee's assisted living with dementia care contract, and LALD-B indicated the documents in the binder were current. R3 and R4's written contract included a Right To Designate A Representative For Certain Purposes notice with the required statutory language, and page 20 indicated a space for the resident to identify a designated representative or documentation that they declined to name a designated representative; however, the form was left blank.	0 950		

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0 950	Continued From page 27 R3 R3 was admitted on February 14, 2020, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021. R3's record included an Assisted Living Contract, dated August 1, 2021, signed by R3 on July 30, 2021; however, R3's record lacked an assisted living with dementia care contract with the above required content. R4 R4 was admitted on September 1, 2016, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021. R4's record included an Assisted Living Contract, dated August 1, 2021, signed by R4 on July 30, 2021; however, R4's record lacked an assisted living with dementia care contract with the above required content. On February 16, 2023, at 10:40 a.m., LALD-B stated the licensee's contract had been revised and residents that had been admitted in the last year and a half, had received the newest contract. LALD-B stated addendums to the contract had been provided to those residents admitted prior to the use of the newest contract. LALD-B stated R3 and R4 had the required statutory language in their record for the resident to identify a designated representative or documentation that they declined to name a designated representative; however, the documents had not been discussed with R3 and R4 and were blank and not completed.	0 950		

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0 950	Continued From page 28 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 29 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 notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation 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, 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: R5's record lacked evidence of notification to the OOLTC when R5 did not return to the facility within four days following an emergency relocation, as required. R5 was admitted to the licensee on March 9, 2021, with diagnoses including epilepsy, cyst of kidney, gastroesophageal reflux, dependence on supplemental oxygen, type 2 diabetes with diabetic ophthalmic (eyes) complication, chronic	01060		

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01060	Continued From page 30	01060		

kidney disease, depression, and insomnia (inability to sleep). R5 was discharged on January 31, 2023, to a different facility.

R5's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated August 11, 2022, unsigned due to family's refusal, indicated R5 received assistance with dressing, grooming, transfer, medication administration, oxygen management, compression stockings on/off, toileting/incontinence assistance, whirlpool, housekeeping, and laundry.

R5's Discharge Summary, dated January 31, 2023, indicated R5 had a sore ankle and was requiring assistance of two to three staff and the licensee was unable to meet R5's needs. After discussion with guardian and with their permission for evaluation, R5 was sent to the emergency department on January 19, 2023, via emergency medical services. R5's family came to the facility "a few days later" and moved all of his belongings out of the facility, demanded his medications, and would not inform the licensee of what was happening with R5's care. The hospital notified the licensee that R5 had been discharged to a different facility.

R5's record included an Emergency Notice of Relocation from Assisted Living, dated January 19, 2023, which indicated the notice was given to R5 and/or R5's representative on January 19, 2023, at 3:50 p.m., and noted the emergency relocation reason was necessary for the resident's welfare because the resident's needs could not be met by the facility. The notice indicated the location of the relocation was St. Cloud Hospital, included contact information for the Office of Ombudsman for Long-Term Care,

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01060	Continued From page 31 the return date of the resident was unknown at the current time, and included information regarding the resident's appeal rights regarding the relocation with contact information for the agency to which the resident may submit an appeal. R5's record lacked evidence of notification to the Office of Ombudsman for Long-Term Care when R5 did not return to the facility within four days, as required. During an interview on February 13, 2023, at 2:09 p.m., LALD-B stated she was unaware of the requirement to notify the OOLTC if the resident had been relocated and had not returned to the facility within four days. The licensee's Notice of Emergency Relocation policy, updated December 20, 2022, indicated the resident, resident's designated representative, and the resident's legal representative(s) would be given a notice of emergency relocation for any relocation to acute care, an emergency department, or any other emergent relocation from the community, and would be given prior to or within 48 hours of relocation from the community. The policy noted copies of the notice would be sent to the OOLTC if the relocation exceeded four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 32 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of four employees (unlicensed personnel (ULP)-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate correction order on February 16, 2023. The findings include: ULP-E had a hire date of January 5, 2023. ULP-E's employee record lacked evidence of a	01290	On February 17, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope and level of G.	

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01290	Continued From page 33 completed background clearance letter. On February 13, 2023, at 12:40 p.m., the evaluator observed ULP-E assist an unidentified female resident to eat in the dining room in the secured memory care unit. On February 13, 2023, at 1:06 p.m., the evaluator observed ULP-E assist R1 from the dining room in the secured memory care unit to R1's apartment. ULP-E offered for R1 to use the restroom; R1 declined. ULP-E assisted R1 to transfer into bed. On February 15, 2023, at 9:01 a.m., the evaluator observed ULP-E tie an unidentified resident's shoelace near the elevator in the common area of the assisted living facility. ULP-E stated she worked throughout the building, both in the memory care unit and in the assisted living area. Review of the Ridgeview-Accura Healthcare schedule, week of February 12, 2023, indicated ULP-E was scheduled to work the following: - On February 13, 2023, ULP-E was scheduled to work 6:30 a.m. to 2:30 p.m., in the memory care unit as the medication passer. - On February 14, 2023, ULP-E was scheduled to work 6:30 a.m. to 2:30 p.m., in the memory care unit as a caregiver. - On February 15, 2023, ULP-E was scheduled to work 6:30 a.m. to 2:30 p.m., in the assisted living unit as a caregiver. - On February 16, 2023, ULP-E was scheduled to work 6:30 a.m. to 2:30 p.m., in the memory care unit as the medication passer. During a phone interview on February 16, 2023, at 1:50 p.m., licensed assisted living director (LALD)-B stated the business office manager	01290		

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01290	Continued From page 34 (BOM)-I was on the telephone with the Department of Human Services (DHS) at this time, because the online verification indicated that ULP-E was "disassociated" from the facility on January 12, 2023, and they were not sure why. On February 16, 2023, at 2:00 p.m., BOM-I stated ULP-E had not finished her consent with DHS, therefore was "disassociated" and BOM-I stated she did not realize that this had occurred. BOM-I stated, "It slipped through the cracks," because she understood that once the Final Registry Results Form was received, the employee was cleared to work on the floor. BOM-I stated she now understood that the background clearance letter needed to be received prior to new employees working. BOM-I she "ran" ULP-E's background study again today and stated ULP-E was scheduled for fingerprinting on February 17, 2023, at 10:20 a.m. On February 16, 2023, at 2:13 p.m., CNS-A stated ULP-E had worked on the memory care unit today starting at 6:30 a.m., and stated she had just removed her from the facility and taken her off of the schedule until a background study clearance was received. The licensee's New Hire Procedure Policy, undated, indicated the licensee would follow the following process for new employees to evaluate their ability to provide care: - Conditional job offer extended contingent on successful completion of an appropriate state background check. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		

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01470	Continued From page 35	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 36 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 employees received orientation to assisted living licensing requirements and regulations prior to providing services for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-A, ULP-E, and ULP-F's employee records	01470		

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01470	Continued From page 37 lacked documented evidence of the following: - an overview of Assisted Living statutes. CNS-A was hired to provide direct care and assisted living services on March 8, 2022. On February 13, 2023, at 3:30 p.m., the evaluator accompanied CNS-A to visit R4 in his apartment. R4 was transferring himself into the wheelchair after using the restroom. R4 was alert, talkative, and discussed how uncomfortable his current bed and mattress were. ULP-E was hired to provide direct care and assisted living services on January 5, 2023. On February 13, 2023, at 1:06 p.m., the evaluator observed ULP-E bring R1 to her apartment and assist her to get into bed. ULP-F was hired to provide direct care and assisted living services on July 21, 2021. On February 15, 2023, at 9:27 a.m., the evaluator and ULP-F entered R3's apartment. The evaluator observed while ULP-F demonstrated the process of glucose monitoring for R3. R3 was sitting on her sofa in her apartment with her eyes closed initially, but did awaken and visited briefly with ULP-F. On February 17, 2023, at approximately 8:25 a.m., CNS-A stated she provided the orientation training to employees, and stated she did not provide an overview of the Assisted Living statutes, and stated she had not received an overview with her orientation. CNS-A stated she was not aware of the requirement to do so. The licensee's Orientation for Assisted Living	01470		

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01470	Continued From page 38 Staff policy dated effective August 1, 2021, noted all staff providing and supervising direct care services must complete an orientation to assisted living to include an overview of sections 144G.01 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 39 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment and monitoring using the uniform assessment tool for one of four 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 admitted to the facility on January 18, 2023, with diagnoses including dementia with behavioral disturbances and hypertension (high blood pressure). R2's Amendment to Addendum A (Section IV-2), identified as the service plan, dated January 18, 2023, noted services including medication administration, grooming, dressing, and toileting. R2's record contained a progress note dated February 1, 2023, which noted "14 day assessment completed with tenant [resident]. No changes needed at this time. POA (power of attorney) notified." On February 16, 2023, at approximately 9:55 a.m., clinical nurse supervisor (CNS)-A stated for the 14-day reassessment, she sees the resident to see if the services provided are ok, and does	01620		

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01620	Continued From page 40 not do a full assessment using the uniform assessment tool. CNS-A stated the corporate office told her the note was all she had to do. The licensee's Comprehensive Assessment Schedule dated July 15, 2021, noted no more than 14 calendar days after initiation of services a resident reassessment and monitoring would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 41 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for four of four residents (R1, R2, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 R1's diagnoses included cognitive decline, type 2 diabetes mellitus, and hypertension (high blood pressure). R1's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated August 17, 2022, indicated R1 required services including monthly wellness checks, medication administration, bathing, escort assistance, safety checks, toileting, grooming, dressing, transfer assistance, daily weight, housekeeping, and laundry. The	01650		

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01650	Continued From page 42	01650		

amendment lacked identification of the ordered heart healthy diet, and lacked the following:
- the schedule and methods of monitoring staff providing services;
- a contingency plan that included:
  - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
  - 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.

R1's prescriber orders dated September 12, 2022, included a diet of heart healthy.

R2
R2's diagnoses included dementia with behavioral disturbances and hypertension (high blood pressure).

R2's Amendment to Addendum A (Section IV-2), identified as the service plan, dated January 18, 2023, noted services including medication administration, grooming, dressing, and toileting. The amendment lacked identification of the ordered blood pressure monitoring, and lacked the following:
- the schedule and methods of monitoring staff providing services; and
- a contingency plan that included:
  - 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

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01650	Continued From page 43 chapters. R2's prescriber orders dated January 27, 2023, included twice weekly blood pressure checks on Monday and Wednesday. R3 R3's diagnoses included diabetes, insomnia (inability to sleep), dementia, and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). R3's Amendment to Addendum A, identified by LALD-B as the service plan, signed April 21, 2022, indicated R3 required services including monthly wellness checks, medication administration, blood sugar monitoring, housekeeping, and laundry. The amendment lacked identification of the ordered compression stockings, and lacked the following: - the schedule and methods of monitoring staff providing services; - a contingency plan that included: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3's prescriber orders dated April 21, 2022, included compression stockings to bilateral lower extremities, on in the morning, off at bedtime.	01650		

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01650	Continued From page 44 R4 R4's diagnoses included chronic obstructive pulmonary disease, ataxia (poor muscle control that causes clumsy voluntary movements, causing difficulty with walking and balance), spinal stenosis lower back (space inside the backbone is too small causing pressure on spinal cord and nerves), anxiety, and polyneuropathy. R4's Amendment to Addendum A, identified by LALD-B as the service plan, dated April 14, 2022, and signed by R4 on August 15, 2022, indicated R4 received services including escort services to remind and escort to meals, medication administration, control drug count, oxygen management, daily safety checks, toileting/incontinence assistance, housekeeping, and laundry. The amendment lacked the following: - the schedule and methods of monitoring staff providing services; - a contingency plan that included: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On February 16, 2023, at approximately 9:10 a.m., clinical nurse supervisor (CNS)-A stated the above required content was not in the service plan. CNS-A stated the information is checked in the electronic record, but not carried over to the	01650		

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01650	Continued From page 45 service plan, which she said she enters manually at this time. CNS-A also said the same service plan format is utilized for all residents. CNS-A also stated she was not aware the treatments were required to be noted on the service plan. On February 16, 2023, at approximately 10:40 a.m., licensed assisted living director (LALD)-B stated the information with the names and contact information of the persons the resident wished to have notified has been changed in some of the contracts, but not all, and R2 was a newer resident, and has the newer version with this information included. The licensee's Service Plans policy dated reviewed August 2021 noted the service plan must include the frequency of sessions of supervision of staff and type of personnel who would supervise staff, and a contingency plan that included the names and contact information of persons the client [resident] wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the client in an emergency, and the circumstances in which emergency medical services are not to be summoned consistent with chapters 144B and 145C, and declarations made by under those chapters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 46 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed and administered as prescribed for one of three residents (R7) observed during medication administration. 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: R7's diagnoses included atrial fibrillation (an irregular and often very rapid heart rhythm), need for assistance with personal care, atherosclerotic heart disease, acute kidney failure, chronic	01760		

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01760	Continued From page 47 kidney disease, major depressive disorder, and gastroesophageal reflux disease (stomach acid repeatedly flows back into the esophagus.) R7's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated July 20, 2022, indicated R7 received services including compression wraps, bathing assistance, weight monitoring, medication administration, housekeeping, and laundry. R7's Physician Order Sheet, dated September 12, 2022, included Tylenol (pain reliever) 8 Hour Arthritis Pain 650 mg (milligrams) TCBR (tablet extended release) two tablets by mouth (po) twice daily at 8:00 a.m. and 4:00 p.m. Also included, acetaminophen (same as Tylenol) 325 mg two tablets po every four hours as needed, and noted maximum APAP (acetaminophen) 4 grams (4000 mg)/24 hours. R7's Physician Rounding Form, dated February 6, 2023, indicated "Discontinue current Tylenol dosing. Start Rx [doctor's prescription]: Tylenol 500 mg [one] po [orally] tid [three times per day] and [one] po tid prn [as needed]." The order was signed by the provider on February 6, 2023, signed by licensed practical nurse (LPN)-J on February 6, 2023, and cosigned by LPN-K on February 7, 2023. On February 15, 2023, at 9:12 a.m., the evaluator observed unlicensed personnel (ULP)-F enter R7's apartment to administer R7's medications. ULP-F opened R7's locked medication cupboard in the kitchen, applied hand sanitizer, donned gloves, retrieved Neosporin (antibiotic) ointment from the cupboard, and applied the ointment to a darkened, scabbed area on R7's right cheek. R7 removed the gloves and applied hand sanitizer.	01760		

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01760	Continued From page 48 R7 went back to the medication cupboard and removed a large stack of punch cards with medications. ULP-F reviewed a list of R7's medications on the electronic record on a small tablet, and punched pills from the punch cards into a disposable medication cup, reviewing each medication several times with the directions on the punch card and the electronic record. The medications included: - acetaminophen 500 mg one tablet (dispensed February 6, 2023); - acetaminophen 650 mg two tablets (dispensed January 18, 2023); - gabapentin (treat seizures and nerve pain) 100 mg one tablet; - lisinopril (treat high blood pressure) 40 mg one tablet; - amlodipine (treat high blood pressure) 10 mg one tablet; - probiotic colon health one tablet; - vitamin D 2000 units two tablets; - metoprolol (treat high blood pressure) 25 mg, 1/2 tablet; - PreserVision Areds (eye vitamin supplement) two caplets; - Eliquis (treat blood clots) 5 mg one tablet; - aspirin (prevent heart attack or stroke) 81 mg one tablet; - citalopram (antidepressant) 20 mg one tablet; - glucosamine (supplement for joints) 500 mg two tablets; - omeprazole (treat heartburn and indigestion) 20 mg one tablet; - Senna S (treat constipation) two tablets; and - amiodarone (treat life-threatening heart rhythm problems) 200 mg one tablet. ULP-F brought the medication cup to R7, which she took one at a time with liquid from a glass. ULP-F applied gloves, applied Biofreeze (used on the skin to relieve pain) to R7's knees, and	01760		

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01760	Continued From page 49	01760		

removed the gloves. ULP-F performed hand hygiene with hand sanitizer, applied gloves, and administered artificial tears to both eyes. ULP-F removed the gloves and performed hand hygiene.

R7's Medication Sheet for the month of February 2023 indicated the above medications and noted acetaminophen 500 mg one tablet by mouth three times daily, scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. The Medication Sheet also included "GNP [Good Neighbor Pharmacy] 8 Hour Arthritis Relief 650 mg TBCR, 2 [two] tablets twice daily."

On February 15, 2023, at 3:17 p.m., the evaluator and clinical nurse supervisor (CNS)-A entered R7's apartment. CNS-A unlocked R7's medication cupboard and removed the large stack of medication punch cards, and verified two different punch cards with acetaminophen, one with 500 mg tablets and one with 650 mg tablets, as noted above. CNS-A stated R7 had a recent order change with the acetaminophen and "the card must not have gotten pulled." CNS-A stated she would investigate.

On February 15, 2023, at 3:25 p.m., CNS-A provided progress note dated February 6, 2023, that indicated the acetaminophen order had been changed. CNS-A stated LPN-J had taken the order and discontinued the acetaminophen 325 mg two tablets every four hours as needed, as noted on the September 12, 2022, order; however, did not realize GNP 8 Hour Arthritis Relief 650 mg contained acetaminophen and did not discontinue the order and did not pull the medication punch card from the medication cupboard. CNS-A indicated, as a result, R7 received 3100 mg of acetaminophen on February 7, 2023, and had received 4100 mg of

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01760	Continued From page 50 acetaminophen daily from February 8, 2023, through February 14, 2023, which exceeded the physician's order of maximum of 4000 mg/24 hours. CNS-A stated she pulled the medication punch card with the incorrect dosage from the medication cupboard, notified R7's physician, performed vitals, and would initiate risk management. CNS-A stated orders would be reviewed by a registered nurse (RN) going forward and would ensure provider wrote clear orders to ensure errors did not occur. The licensee's Medication & Treatment Orders policy, revised December 2022, indicated a RN, LPN, therapist, or person qualified to receive orders would obtain all medication orders either in writing, verbally, or electronically by an authorized prescriber. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790		

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RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 51 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790		

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01790	Continued From page 52 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 13, 2023, at 9:15 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Administration policy, revised December 12, 2022, differentiated planned or unplanned time away from the facility,	01790		

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01790	Continued From page 53 and noted for planned time away, the licensed staff member would notify the pharmacy at least seven days in advance and the pharmacy would package the medications. For unplanned time away, when the pharmacy was not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel (ULP) may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence. For unplanned time away when a pharmacist or licensed nurse was not available, the registered nurse (RN) may delegate this task to ULP if: - The RN has developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. On February 16, 2023, at 10:29 a.m., CNS-A stated medications were only sent "when necessary" with residents that had planned or unplanned time away from the facility, and stated a RN or licensed practical nurse (LPN) were usually available during the day and evening shift to provide the needed medications. CNS-A stated in the event a licensed nurse was not available, ULP may need to provide the medications and had been trained to do so; however, stated there was no written procedures for the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12	01830		

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01830	Continued From page 54 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked an annual renewal of prescriber orders for medications. R3's diagnoses included diabetes, insomnia (inability to sleep), dementia, and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). R3's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, signed April 21, 2022, indicated R3 required services including monthly wellness checks, medication administration, blood sugar monitoring, housekeeping, and laundry. R3's Medication/Treatment Individual Management Plan, dated January 3, 2023,	01830		

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01830	Continued From page 55 indicated R3 received medication administration by facility staff. On February 15, 2023, at 9:27 a.m., the evaluator and unlicensed personnel (ULP)-F entered R3's apartment. The evaluator observed while ULP-F demonstrated the process of glucose monitoring for R3. R3 was sitting on her sofa in her apartment with her eyes closed initially, but did awaken and visited briefly with ULP-F. R3's Medication Sheet, dated February 2023, included the following medications: - aspirin (prevent heart attack or stroke) 81 milligrams (mg) one tablet by mouth (po) daily; - oyster shell calcium (supplement) 500 mg one tablet po once daily; - rosuvastatin calcium (treat high cholesterol) 5 mg one tablet po once daily; - metformin (treat high blood sugar) hydrochloride extended release 500 mg four tablets po daily; - acetaminophen (pain reliever) extra strength 500 mg two tablets every night at bedtime; - gabapentin (treat seizures or nerve pain) 100 mg one capsule at bedtime; - melatonin (for sleep) 3 mg one tablet po at bedtime; - acetaminophen 500 mg two capsules three times daily as needed; and - ondansetron hydrochloride (prevent nausea/vomiting) 4 mg one tablet po every 8 hours as needed. R3's most current prescriber orders, dated January 10, 2022, included all of the above medications; however, was 37 days past the annual renewal date requirement. On February 16, 2023, at 11:09 a.m., clinical nurse supervisor (CNS)-A stated R3's prescriber	01830		

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01830	Continued From page 56 orders had not been updated at least annually as required. The licensee's Medication & Treatment Orders policy, revised December 2022, indicated the licensed nurse would ensure that the prescriber renews a medication order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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02040	Continued From page 57 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on February 15, 2023, at approximately 3:00 p.m. with Maintenance Staff (MS)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, MS-H stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills;	02170		

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02170	Continued From page 58 (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for four of four residents (R1, R2, R3, and R4) who resided in the assisted living with dementia care facility.	02170		

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02170	Continued From page 59 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. R1 R1's diagnoses included cognitive decline, type 2 diabetes mellitus, and hypertension (high blood pressure). R1's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated August 17, 2022, indicated R1 required services including monthly wellness checks, medication administration, bathing, escort assistance, safety checks, toileting, grooming, dressing, transfer assistance, daily weight, housekeeping, and laundry. R1's Initial/Progress Note dated January 20, 2023, noted R1's past and current interests and adaptations necessary for the resident to participate. However, it lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 60 In addition, R1's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate. R2 R2's diagnoses included dementia with behavioral disturbances and hypertension (high blood pressure). R2's Amendment to Addendum A (Section IV-2), identified as the service plan, dated January 18, 2023, noted services including medication administration, grooming, dressing, and toileting. R2's Initial/Progress Note dated January 20, 2023, noted R2's past and current interests. However, it lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate. R3 R3's diagnoses included diabetes, insomnia (inability to sleep), dementia, and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body). R3's Amendment to Addendum A, identified by LALD-B as the service plan, signed April 21, 2022, indicated R3 required services including	02170		

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02170	Continued From page 61 monthly wellness checks, medication administration, blood sugar monitoring, housekeeping, and laundry. R3's Initial/Progress Note dated December 9, 2022, noted R3's past and current interests and adaptations necessary for the resident to participate; however, lacked an evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; and - identification of activities for behavioral interventions. In addition, R3's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate, as required. R4 R4's diagnoses included chronic obstructive pulmonary disease, ataxia (poor muscle control that causes clumsy voluntary movements, causing difficulty with walking and balance), spinal stenosis lower back (space inside the backbone is too small causing pressure on spinal cord and nerves), anxiety, and polyneuropathy. R4's Amendment to Addendum A, identified by LALD-B as the service plan, dated April 14, 2022, and signed by R4 on August 15, 2022, indicated R4 received services including escort services to remind and escort to meals, medication administration, control drug count, oxygen management, daily safety checks, toileting/incontinence assistance, housekeeping and laundry. R4's Initial/Progress Note dated December 16,	02170		

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02170	Continued From page 62 2022, noted R4's past and current interests and adaptations necessary for the resident to participate; however, lacked an evaluation of the following: - current abilities and skills; - emotional needs and patterns; - physical abilities and limitations; and - identification of activities for behavioral interventions. In addition, R4's record lacked an individualized activity plan to include a selection of daily structured and non-structured activities as appropriate, as required. On February 14, 2023, at 2:03 p.m., activities director (AD)-L stated she completed the activity evaluation for each resident, gathering as much information as she could from the resident. AD-L stated she was fairly new to the facility and was not aware that an individualized activity plan needed to be completed for each resident, therefore, she had not done this for any of the residents. The licensee's ALDC (assisted living dementia care) Life Enrichment Programs, Activities & Outdoor Space policy, dated November 10, 2022, indicated each resident must be evaluated for activities according to the licensing rules of the facility. The evaluation must address the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions.	02170		

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02170	Continued From page 63 In addition, the policy directed an individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02180		

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02180	Continued From page 64 review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of one resident (R1) with behaviors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care (ALFDC) license effective August 1, 2022. On February 13, 2023, at approximately 10:20 a.m., during the facility tour, the evaluators observed R2 walking in the hallway with staff. The evaluators were at a corner and moved out of the way to allow R2 and the staff person to pass. R2 glared at the surveyors and continued walking. Licensed assisted living director (LALD)-B who was present stated walking was one of the things that helps R2 to calm down. R2's diagnoses included dementia with behavioral disturbances and hypertension (high blood pressure). R2's Amendment to Addendum A (Section IV-2), identified as the service plan, dated January 18, 2023, noted services including medication administration, grooming, dressing, and toileting. However, it lacked identification of R2's behaviors.	02180		

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02180	Continued From page 65 R2's Master Assessment - Condensed dated January 18, 2023, noted short-term memory impairment, long-term memory impairment, and mild cognitive impairment diagnosis. It noted R2 always required reassurance/redirection with severe disorientation to person, place, or time. It also noted R2 would pace and be verbally abusive to others when agitated, had hallucinations, pacing, often refused shower per daughter's report, and frequently required redirection as she may be mean to others, and needed supervision when around others. It also noted a behavior management plan was indicated. R2's Nursing Assessment dated January 18, 2023, noted R2 as alert, oriented to person, paranoid, confused, impaired decision making, wandered, memory loss, and physical or verbal behavior issues. R2's Service Checkoff List for February 2023 noted at 6:00 a.m., 2:00 p.m., and 10:00 p.m. "Behavior Monitoring. Please document any behaviors tenant [resident] had on your shift." Various days had marked "0", sleeping, anxious, walking, pacing, yes, behaviors, none, agitated after noon, mild behaviors, in her room. On February 16, 2023, at approximately 9:55 a.m., clinical nurse supervisor (CNS)-A stated all staff have training related to behaviors with dementia training. She stated the documentation of the behaviors includes three interventions to try, including verbal redirection, walking, and distraction. CNS-A stated the same three interventions were noted for any resident with behaviors, and were not individualized. In addition, CNS-A stated the interventions that were	02180		

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	20619	A. BUILDING: _____ B. WING _____	02/17/2023

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02180	Continued From page 66 tried were not documented by staff for any resident with behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R1, R4) with an assistive device, and one of one resident (R6) with a hospital bed with bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order for correction on February 14, 2023.	02310	The immediacy for the correction order identified on February 14, 2023, issued for SL20619015-0, tag identification 2310, is removed as of, February 15, 2023. The scope and level remain unchanged.	

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02310	Continued From page 67 The findings include: ASSISTIVE DEVICE R1 R1's diagnoses included cognitive decline, type 2 diabetes mellitus, and hypertension (high blood pressure). R1's Amendment to Addendum A, identified by licensed assisted living director (LALD)-B as the service plan, dated August 17, 2022, indicated R1 required services including monthly wellness checks, medication administration, bathing, escort assistance, safety checks, toileting, grooming, dressing, transfer assistance, daily weight, housekeeping, and laundry. On February 13, 2023, at 1:06 p.m., the evaluator observed unlicensed personnel (ULP)-E assist R1 back to her room from the dining room. R1 stated she wanted to get in bed to rest, so ULP-E assisted her to stand and walk to bed. The evaluator observed R1 grab the device on the right side of her full-sized bed with her right hand and then sit down. ULP-E assisted R1 to raise her feet onto the bed and to reposition to the middle of the bed. R1 held the device the whole time. On February 13, 2023, at 2:40 p.m., the evaluator and clinical nurse supervisor (CNS)-A observed R1 in her bed. CNS-A read the tag attached to R1's device on the right side of the bed, and noted it was Stander Inc. lot number 21-228. CNS-A stated she was not sure if the former registered nurse (RN) checked the Consumer Product Safety Commission (CPSC) website for product recall information.	02310		

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02310	Continued From page 68 R1's Bed Mobility Assistive Devices Acknowledgement form dated June 27, 2022, noted "Resident agrees not to use or apply grab bars or other bed mobility device of any type without first notifying the facility and allowing the facility to conduct an assessment to determine the risk/benefit of assistive device use. Resident acknowledges that bed mobility assistive devices on the bed are often considered a restraint and may cause serious injury, including: fractures, asphyxiation, strangulation and death. In the event it is determined by facility staff that the device poses a greater risk for injury than benefit for resident's use, resident agrees not to apply/utilize the device." It also noted "The facility's maintenance staff will be responsible for applying all bed mobility assistive devices and measurement of all areas/zones of risk to ensure the greatest safety possible with the device." It added "Maintenance will also conduct ongoing safety assessment/monitoring." R1's Master Assessment - Condensed, noted as a 90-day assessment dated January 15, 2023, indicated R1 required physical assist of one for transfers, ambulation, and getting in and out of bed. It also noted R1 utilized bed rails for bed mobility and required fall risk safety checks. In addition, the assessment indicated R1 had short term memory impairment and anxiety disorder. R1's Nursing Assessment, noted as an annual assessment dated January 15, 2023, indicated R1 was alert, oriented to person and place, forgetful, confused, and had impaired decision making. The assessment also noted R1 had a risk or history of falls. R1's Physical Device assessment dated January	02310		

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02310	Continued From page 69 15, 2023, indicated the following: - 1. Bed "Rails on Bed (includes but not limited to U-bar, grab bar, 1/2 SR [side rail]"; - 3. Type of bed rail noted "U type grab bar"; - 4. Location on bed noted "Right"; - 5. Does the tenant have sufficient upper body strength to pull/push self up from lying position noted "Yes"; - 6. Tenant assessed for entrapment risk. Bed, mattress, and tenant weight appropriate for device noted "Yes"; - 7. Informed consent for device given to tenant or tenant representative noted "Yes"; - The form also contained a section titled Risks and Benefits of Rail. Explain risk and benefits of rails, noted "A. Aid in turning and repositioning, can provide a hand hold for getting out of bed or repositioning while in bed, provide a feeling of comfort and security, and can provide easy access to bed controls and personal care items. B. Strangling, suffocating, bodily injury or death when body or part of body are caught between bed rails or between the bed rails and mattress, more serious injury from falls when climbing over rails, skin bruising, cuts or scrapes, including agitated behavior when bed rails are used and can cause feelings of isolation or unnecessary restrictions."; - Under medical symptoms, weakness, pain, and to facilitate independence; - R1 was alert, orientated, confused, with poor short term memory; - The device would not restrict tenant from movement or normal access to body; - The summary noted the device would be used for "A. Mobility enabler/enhancer B. Positioning C. Safety D. Personal preference."; and - The last section noted the interdisciplinary team felt the device was appropriate.	02310		

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02310	Continued From page 70 On February 13, 2023, at 3:07 p.m., CNS-A stated R1's electronic assessment did not have a spot to document the licensee had checked for recalls and indicated she was unable to produce evidence to show it was done. In addition, CNS-A stated bedrail installations were completed by facility maintenance personnel who she believed would have reviewed the manufacturer's guidelines when they completed the installation, however, no documentation was available in the resident record for verification. CNS-A stated the resident record lacked documented evidence of the device being installed per manufacturer guidelines. CNS-A later stated she was able to locate the manufacturer's guidelines online during the survey. On February 13, 2023, at 4:00 p.m., the evaluator observed R1's bed with CNS-A. The bed was a full-sized mattress pushed against the wall on the left side. The mattress was raised to observe the assistive device. The device was a black color with a bar that came up and had an oval handle on top with an opening for the resident to grip. The opening appeared to be less than 4 inches. Coming down on the lower part of the bar was another bar attached in the middle, that curved down on both sides and then curved towards the center of the bed. The rail reached approximately halfway underneath the mattress. The end on both sides facing the wall had a black flat strap approximately one inch wide attached to both ends of the device. Another strap was attached to the end with a metal hook. This strap was brought down around the bed frame to the right side of the bed frame, and brought back to the left side of the frame, where it was tied. A buckle was attached to both ends of the strap. However, one half of the buckle was noted below the mattress near the device and the second half of the buckle	02310		

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02310	Continued From page 71 was noted underneath the bed frame. The buckle was not connected as instructed in the manufacturer guidelines. R1's record lacked documentation that the device was installed per manufacturer's guidelines or that the licensee referred to the CPSC for the most up-to-date information related to portable bed side rail recall information. R4 On February 13, 2023, at 3:20 p.m., CNS-A and LALD-B reviewed the current resident roster with the evaluators and, although there was no check mark that indicated R4 had a bedrail, CNS-A and LALD-B stated they were certain he had a hospital type bed with one hospital type bedrail on one side; neither CNS-A nor LALD-B could describe what the bedrail looked like. On February 13, 2023, at 3:30 p.m., the evaluator and CNS-A entered R4's apartment, with his permission, and observed R4's hospital bed had a single vertical, metal, circular-shaped assistive device, ivory in color, attached to the right side of the bed frame. The device had seven openings within the large circle. R4 stated he used the device to assist him to get in and out of bed and to reposition while in bed. The device had minimal movement when grasped by the evaluator. R4's diagnoses included chronic obstructive pulmonary disease, ataxia (poor muscle control that causes clumsy voluntary movements), cervical disc degeneration, spinal stenosis (spaces in the spine narrow and create pressure on the spinal cord and nerve roots), and rheumatoid arthritis.	02310		

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02310	Continued From page 72 R4's Amendment to Addendum A, identified as the service plan by LALD-B, dated August 15, 2022, indicated R4 received services including escort assistance, medication administration, injection administration, oxygen management, safety checks, toileting assistance, housekeeping, and laundry. R4's Bed Mobility Assistive Devices Acknowledgement, signed by R4 on October 5, 2022, noted "Resident agrees not to use or apply grab bars or other bed mobility device of any type without first notifying the facility and allowing the facility to conduct an assessment to determine the risk/benefit of assistive device use. Resident acknowledges that bed mobility assistive devices on the bed are often considered a restraint and may cause serious injury, including: fractures, asphyxiation, strangulation and death. In the event it is determined by facility staff that the device poses a greater risk for injury than benefit for resident's use, resident agrees not to apply/utilize the device." The acknowledgement also noted "The facility's maintenance staff will be responsible for applying all bed mobility assistive devices and measurement of all areas/zones of risk to ensure the greatest safety possible with the device." Also included, "Maintenance will also conduct ongoing safety assessment/monitoring." R4's Master Assessment-Condensed, identified as the 90-day assessment dated February 9, 2023, indicated R4 had short term memory impairment, weakness in the whole body with weakness in fingers, was non-ambulatory, and independent with mobility, transfers, and getting in and out of bed. The assessment noted R4 was independent with dressing, grooming, toileting, and oral care, and needed assistance with medication administration and bathing.	02310		

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02310	Continued From page 73 R4's Physical Device assessment, dated February 9, 2023, indicated the following: - 1. Bed: A. "Rails on Bed (includes but not limited to U-bar, grab bar, 1/2 SR [side rail])."; - 2. "Bed rail on right side of bed"; - 3. Type of bedrail indicated "Grab bar"; - 4. Location on the bed noted "Right"; - 5. Does the tenant have sufficient upper body strength to pull/push self up from lying position? which noted "Yes"; - 6. Tenant assessed for entrapment risk. Bed, mattress, and tenant weight appropriate for device, noted "Yes"; - 7. Informed consent for device given to tenant or tenant representative, noted "Yes"; - The form also contained a section titled Risks and Benefits of Rails, and included, -"Explain Risk and Benefits of Rails. A. Aid in turning and repositioning, can provide a hand hold for getting out of bed or repositioning while in bed, provide a feeling of comfort and security, and can provide easy access to bed controls and personal care items. B. Strangling, suffocating, bodily injury or death when body or part of body are caught between bed rails or between the bed rails and mattress, more serious injury from falls when climbing over rails, skin bruising, cuts or scrapes, including agitated behavior when bed rails are used and can cause feelings of isolation or unnecessary restrictions." - The assessment indicated R4 was alert, oriented, confused, and used a wheelchair; - Medical symptoms included weakness, impaired mobility, pain, fatigue, and the bedrails helped to facilitate independence; - The assessment noted R4 could follow directions, was able to retain safety information, and the device would not restrict movement or	02310		

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02310	Continued From page 74 normal access to body; and - In summary, the assessment indicated the device would be used for mobility enabler/enhancer and personal preference and the interdisciplinary team felt the device was appropriate. On February 13, 2023, at 3:40 p.m., CNS-A stated R4 had the bed and device prior to her employment with the licensee and stated she was not aware of any documented evidence of the device being installed per manufacturer guidelines or that the licensee had checked the CPSC for a recall on the device. R4's record lacked documentation that the device was installed per manufacturer's guidelines or that the licensee referred to the CPSC for the most up-to-date information related to portable bed side rail recall information. On February 14, 2023, at 8:27 a.m., the evaluator observed a man enter the facility through the main entrance and hand CNS-A the manufacturer's guidelines for R4's bedrail. CNS-A stated they had attempted to find the guidelines online last evening to ensure the device was installed correctly; however, were not able to find R4's device online, therefore, requested a copy from the medical supply company. HOSPITAL BED WITH BEDRAILS R6 On February 14, 2023, at 8:27 a.m., LALD-B provided an updated resident roster and stated they went through the list last evening and updated the list with residents that currently had bedrails, deleting some from the previous list provided to evaluators and adding new residents.	02310		

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02310	Continued From page 75 LALD-A stated R6 had a hospital bed with hospital bedrails. On February 14, 2023, at 8:35 a.m., the evaluator and CNS-A entered R6's room with her permission. R6's hospital bed had bilateral black metal bedrails in the raised position, with the left bedrail against the wall. The right bedrail was loose and could easily be moved from side to side and front to back when grasped. The evaluator observed CNS-A measure the bedrails. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 3.5 inches. The measurements between the bottom of the rail and the top of the mattress for zone 2, was zero inches. The measurements between the mattress and the bedrail for zone 3, measured 1 3/8 inch. The measurements under the rail, at the ends of the rail for zone 4, measured zero inches. CNS-A stated R6 used the bedrails to help her sit up, transfer in and out of bed, and to reposition herself while in bed. R6's diagnoses included chronic abdominal pain, chronic respiratory failure with hypoxia (low levels of oxygen), hypertension, morbid obesity, depression, anxiety, and obstructive sleep apnea (sleep disorder in which breathing starts and stops). R6's Amendment to Addendum A, identified as the service plan, dated February 2, 2023, indicated R6 received services including assistance with bathing, dressing, grooming, medication administration, daily weight, compression stockings, toileting, oxygen management, escort assistance, behavior monitoring, ambulation, housekeeping, and laundry.	02310		

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02310	Continued From page 76 R6's Bed Mobility Assistive Devices Acknowledgement, signed by R6 on October 17, 2022, noted "Resident agrees not to use or apply grab bars or other bed mobility device of any type without first notifying the facility and allowing the facility to conduct an assessment to determine the risk/benefit of assistive device use. Resident acknowledges that bed mobility assistive devices on the bed are often considered a restraint and may cause serious injury, including: fractures, asphyxiation, strangulation and death. In the event it is determined by facility staff that the device poses a greater risk for injury than benefit for resident's use, resident agrees not to apply/utilize the device." The acknowledgement also noted "The facility's maintenance staff will be responsible for applying all bed mobility assistive devices and measurement of all areas/zones of risk to ensure the greatest safety possible with the device." Also included, "Maintenance will also conduct ongoing safety assessment/monitoring." R6's Master Assessment-Condensed, identified as change of condition assessment after return from hospital, dated January 17, 2023, indicated R6 had mild cognitive impairment, required standby assistance during transfers and ambulation, and had a history of falls. R6's Physical Device assessment, dated January 17, 2023, noted: - 1. Bed: A. "Rails on Bed (includes but not limited to U-bar, grab bar, 1/2 SR"; - 2. Explain other, "bilateral grab bars,"; - 4. Location of bed, identified "Bilateral"; - 5. Does the tenant have sufficient upper body strength to pull/push self up from lying position? which noted, "No"; - 6. Tenant assessed for entrapment risk. Bed, mattress, and tenant weight appropriate for	02310		

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02310	Continued From page 77 device, noted "Yes"; - 7. Informed consent for device given to tenant or tenant representative, noted "Yes"; - The form also contained a section titled Risks and Benefits of Rails, and included, -"Explain Risk and Benefits of Rails. A. Aid in turning and repositioning, can provide a hand hold for getting out of bed or repositioning while in bed, provide a feeling of comfort and security, and can provide easy access to bed controls and personal care items. B. Strangling, suffocating, bodily injury or death when body or part of body are caught between bed rails or between the bed rails and mattress, more serious injury from falls when climbing over rails, skin bruising, cuts or scrapes, including agitated behavior when bed rails are used and can cause feelings of isolation or unnecessary restrictions." - The assessment indicated R6 was alert and oriented, and used a wheelchair, walker, and electric scooter; - Medical symptoms included weakness and impaired mobility; - The assessment noted R6 could follow directions, was able to retain safety information, and the device would not restrict movement or normal access to body; and - In summary, the assessment indicated the device would be used for mobility enabler/enhancer, personal preference, positioning and safety, and the interdisciplinary team felt the device was appropriate. R6's record lacked documentation of measurements to ensure the bedrails were consistent with the Food and Drug Administration (FDA) guidelines. On February 14, 2023, at 11:10 a.m., CNS-A	02310		

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02310	Continued From page 78	02310		

stated she had measured the zones in the past but wasn't aware that she needed to document the measurements of the zones when assessing a hospital bedrail. CNS-A also indicated she was not aware R6's bedrail was loose and stated she would have maintenance address the issue.

The licensee's Resident Bed Rails and Assistive Devices guideline, dated August 2021, indicated the facility's maintenance staff would be responsible for applying bedrails and measurement of all areas/zones of risk to ensure the greatest safety possible with the bedrails and maintenance would conduct ongoing testing of bedrails, bed frame, and mattress zones. Also included, the facility would adhere to the following assessment and monitoring schedule:
- Initial assessment of the device - Physical Device Assessment;
- Periodic monitoring of the device - Supervisory and Wellness Visits; and
- Quarterly review of device or with change of condition - Physical Device Assessment.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information."

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 79 between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *02/13/23*
Time: 11:44:57
Report: 1037231038

Food and Beverage Establishment Inspection Report

Location:
Ridgeview Senior Living
1009 10th Avenue Ne
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0038946
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202515228
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

SATELITE KITCHEN DISHWASHER WAS REGISTERING A TEMPERATURE AT UTENSIL SURFACE LEVEL OF 154-155 DEG F. REPAIR DISHWASHER TO MAINTAIN UTENSIL LEVEL TEMPERATURE AT A MINIMUM OF 160 DEG F. USE DISHWASHER IN MAIN KITCHEN UNTIL UNIT IN SATELITE IS REPAIRED.

Comply By: 02/13/23

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.

AT TIME OF INSPECTION, THERE WAS NO TEMPERATURE MEASURING DEVICE FOR THE MAIN KITCHEN AND THE SATELITE KITCHEN DISHWASHERS. PROVIDE AS DESCRIBED ABOVE TO CHECK UTENSIL LEVEL TEMPERATURE FOR EACH DISHWASHER.

Comply By: 03/13/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit
Location: DISWASHER
Violation Issued: No

Hot Water: = at 154 Degrees Fahrenheit
Location: DISHWASHER - SATELITE KITCHEN
Violation Issued: Yes

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE - SATELITE KITCHEN
Violation Issued: No

Hot Water: = at 155 Degrees Fahrenheit
Location: DISHWASHER - SATELITE KITCHEN RECHECK
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 186 Degrees Fahrenheit - Location: YAMS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: MIXED VEGETABLES
Violation Issued: No

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

Process/Item: Cooking
Temperature: 175 Degrees Fahrenheit - Location: PORK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: PACKAGED CUT LETTUCE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: PRECOOKED MINI BAKED POTATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: MIXED VEGETABLES - SATELITE KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: MILK CARTON - SATELITE KITCHEN
Violation Issued: No

Type: Full
Date: *02/13/23*
Time: 11:44:57
Report: 1037231038
Ridgeview Senior Living

Food and Beverage Establishment Inspection Report

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

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 1037231038 of 02/13/23.

Certified Food Protection Manager: IONE E GUSTAFSON

Certification Number: 16275 Expires: 10/06/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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

Report #: 1037231038

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1	Date	02/13/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:44:57
Legal Authority MN Rules Chapter 4626		Time Out	

Ridgeview Senior Living	Address: 1009 10th Avenue Ne	City/State: Sauk Rapids, MN	Zip Code: 56379	Telephone: 3202515228
License/Permit #: 0038946	Permit Holder:	Purpose of Inspection: Full	Est Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/13/23

Inspector (Signature) Michelle L Thomas