Electronically Delivered

August 30, 2023

Licensee
Rivers Of Life LLC
6700 Egan Drive
Savage, MN 55378

RE: Project Number(s) SL35978015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	35978	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS OF LIFE LLC	6700 EGAN DRIVE SAVAGE, MN 55378

(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: SL35978015 On July 24, 2023, through July 27, 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 28 active residents, all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care License Provider. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: 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 July 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 2 The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 24, 2023, at 11:10 a.m., during the facility tour the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances, and contact information for the state	0 550		

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0 550	Continued From page 3 and applicable regional Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 24, 2023, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the required grievance notice content was not posted and she is in the process of including it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 4 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 record contained the required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of May 25, 2021. On July 25, 2023, at approximately 8:30 a.m., ULP-B was observed passing medications to the assisted living resident (R3). ULP-B's employee record did not contain a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On July 26, 2023, at 3:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the required job description had been completed, but no documentation was provided. No further information was provided.	0 650		

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0 650	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide minimum emergency generator system load runs and inspections as part of the emergency plan required under	0 680		

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0 680	Continued From page 6 Minnesota Rules, Part 4659.0100 to ensure the proper performance of the generator. 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). The findings include: On July 25, 2023, at approximately 2:45 p.m., survey staff requested records relating to the emergency generator inspections, maintenance, and load test runs for review from the owner (O)-E. Document review and interview with the O-E indicated the licensee failed to provide the required minimum monthly load tests and frequency of weekly inspection records to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. One inspection record, dated 4/28/2022, on an invoice was received from the O-E for review. On July 25, 2023, at approximately 3:30 p.m., the O-E acknowledged the above findings. No further information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the name and title of the person making the entry for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 R2's Service Plan signed April 24, 2022, indicated R2 received assistance with bathing, dressing, laundry, escort/mobility assistance, medication administration, vital signs, blood glucose monitoring, and incontinence care daily.	0 690		

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0 690	Continued From page 8 R2's record included Clinical Update Assessments dated June 19, 2023, and July 25, 2023, indicated as completed in person by a registered nurse (RN). Surveyor reviewed both assessments and licensed practical nurse (LPN)-C was identified as the person who completed assessments in Rtask with RN after her name. R2's records were not authenticated by the name and title of the person making the entry for nursing assessments. R3 R3's Service Plan signed May 19, 2022, indicated R3 received assistance with bathing, dressing, laundry, medication administration, and vital signs. R3's record included a Clinical Update Assessment "reason: 90 days assessment" dated December 15, 2022, indicated was completed in person by a RN. Surveyor reviewed assessment and LPN-C was identified the person completed assessments in Rtask with RN after her name. R3's records were not authenticated by the name and title of the person making the entry for nursing assessments. On July 25, 2023, at 4:02 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated "LPN was in Rtask as RN so she could put in data." LALD/RN-A acknowledged the assessments in Rtask were completed by LPN-C, not a RN. Also, LALD/RN-A verified records were not authenticated by the name and title of the person making the entry for some of the residents. The licensee's Resident Records policy dated August 1, 2021, indicated record entries will be	0 690		

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0 690	Continued From page 9 legible, permanently recorded, dated, and signed by the person making the entry. The resident record is legal document and original entries will not be covered or deleted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 790		

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0 790	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2023, from 1:15 p.m. to 2:45 p.m., survey staff toured the facility with the owner (O)-E. During the tour, survey staff observed the following on portable fire extinguishers: -The licensee failed to maintain the annual servicing of all portable fire extinguishers located throughout the facility. The tags on the extinguishers showed the last date of annual service date of February 2020. -The indicator needle inside the gauge of a portable fire extinguisher located in the corridor near the kitchen was in the low level (red zone). The above findings were visually and physically verified by the O-E accompanying the tour. The O-E stated that he had received a quote. He immediately contacted the contractor to schedule the maintenance of the portable fire extinguishers. On July 25, 2023, at approximately 3:30 p.m., the O-E acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		

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0 800	Continued From page 11	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 are: On July 25, 2023, from 1:15 p.m. to 2:45 p.m., survey staff toured the facility with the owner (O)-E. During the tour, survey staff observed the following: -The corridor fire-rated door into the kitchen failed to close and latch due to the bottom door sweep	0 800		

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0 800	Continued From page 12 installed on the door comprising the corridor egress passageway. The O-E removed the bottom door sweep immediately to address the concern. -The dryer exhaust vent in the laundry room was kinked and disconnected from the dryer connection. The O-E confirmed the finding and made a phone call to have their contractor out to repair the vent. - The electrical panels, switches, and transformers in electrical rooms, and control valves in mechanical rooms were obstructed preventing ready access due to excessive storage. The electrical rooms and mechanical room areas around the control panels/equipment must be maintained free and clear of obstruction for necessary functioning of and access to all equipment. -The licensee failed to maintain the reduced pressure zone backflow preventer device in the custodial room serving the exterior antifreeze fire sprinkler system. The device must be tested annually by an approved testing company to ensure the device is working correctly to prevent cross-connection of antifreeze into the water supply system. The device was tagged with the last tested date October 2020. The above findings were visually and physically verified by the O-E accompanying the tour. On July 25, 2023, at approximately 3:30 p.m., the O-E acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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

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0 810	Continued From page 14 the licensee failed to provide the minimum required number of employee evacuation drills. This has the potential to directly affect the safety of residents receiving care, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 25, 2023, at approximately 2:45 p.m. survey staff reviewed the facility's fire safety and evacuation plan and related documentation. Document review and interview with the owner (O)-E indicated the licensee failed to meet the minimum number of required employee fire evacuation drills for two drills per year per shift with at least one drill every other month. Drill records provided for the review showed a 4-month employee drill gap on October 20, 2022, (10:45 p.m.) and February 23, 2023 (11:00 a.m.). In addition, only a drill record was provided for the night shift performed on October 20, 2022 (10:45 p.m.) for the calendar year 2022. On July 25, 2023, at approximately 3:30 p.m., during the exit interview, the O-E acknowledged the above findings. Additional information was provided by the licensed assisted living director -A via email on July 26, 2023, with employee training documentation on fire safety and evacuation plan.	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=B	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: The licensee's Resident Agreement Assisted Living with Dementia Care dated May 19, 2022, included a clause that indicated "Landlord is not	0 970		

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0 970	Continued From page 16 liable to resident ... for any injury, death or property damage occurring in the apartment or on the community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident ..." The contract further indicated "...resident agrees to hold the landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the landlord's premises." On July 26, 2023, at 3:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated residents who were admitted before August 1, 2021, had a contract that contained a waiver of liability. LALD/RN-A stated the licensee did not make any changes to the residents' contracts that were admitted prior to August 1, 2021. LALD/RN-A stated the licensee updated the assisted living contract effective August 1, 2021, and removed the waiver language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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,	01060		

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01060	Continued From page 17 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 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and	01060		

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01060	Continued From page 18 failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of three residents (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 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: R4 admitted on April 27, 2023. R4's Nurse note dated May 18, 2023, indicated "found resident on floor, daughter contacted, per resident's request, transported via ambulance to [hospital]." R4's Nurse note dated May 23, 2023, indicated "Resident returned via ambulance from hospital stay at [hospital] for right ZMC [bones surrounding the eye socket] fracture, right periorbital [near the eye], nasal bone fracture, and services have been updated for hourly checks." R4's Nurse Note dated May 24, 2023, indicated R4 post hospital follow up from May 18, 2023, and returned May 23, 2023. R4's Service Plan dated April 27, 2023, indicated R4 received services included activities of daily living (ADL), medication management, and monitoring vitals. R4's record lacked a written notice with required	01060		

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01060	Continued From page 19 content for an emergency relocation and notification to the Office of Ombudsman for Long-Term Care with in four days that R4 had been relocated and had not returned to the facility. On July 26, 2023, at 3:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was unaware of the requirement listed above. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01540		

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01540	Continued From page 20 by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (licensed practical nurse (LPN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee has a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021. LPN-C was hired November 09, 2022, and provided direct cares to residents of the facility. LPN-C's employee record indicated one hour of dementia care training completed June 12, 2023. On July 25, 2023, at 4:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided documentation LPN-C had one (1) hour of dementia care training. LALD/RN-A stated they use "Care Academy" for dementia training and the classes were assigned LPN-C to complete. The licensee's Assisted Living Facility With Memory Care Dementia Training policy dated August 1, 2021, indicated direct care staff initial training will be completed within 80 working hours	01540		

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01540	Continued From page 21 of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 22 registered nurse (RN) conducted resident reassessment and monitoring for three of three residents (R2, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: R2 On July 26, 2023, at 11:00 a.m., the surveyor observed wound care with licensed practical nurse (LPN)-D and R2 had a wound on the right heel that was pink with no drainage noted. LPN-E cleaned and applied dressing. Also, surveyor observed bruises to right elbow and right forearm, skin tear on left forearm, and bruises on the legs. LPN-D stated resident had change of condition and resident easily bruises with transfers using the Hoyer to wheelchair. LPN-D stated she communicated the condition change with resident's family/representative. R2 admitted to licensee on March 13, 2023, and began receiving assisted living services. R2's diagnoses included type 2 diabetes mellitus, dementia, and kidney disease stage 3. R2's Service Plan signed April 24, 2022, indicated R2 received assistance with bathing, dressing, laundry, escort/mobility assistance, medication administration, vital signs, blood glucose	01620		

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01620	Continued From page 23 monitoring, and incontinence care daily. R2's record included an admission assessment dated March 14, 2023, completed by licensed assisted living director/RN (LALD)/RN-A, and clinical update assessments dated June 19,2023 and July 25, 2023, the latter completed LPN-C after initiation of the the survey. The assessments completed on June 19, 2023, and July 25, 2023, were completed by license practical nurse (LPN)-C. R2's record lacked evidence a RN conducted resident reassessment and monitoring as required. R2's Nurse Note "90-day assessment" dated June 19, 2023, was completed by LPN-C and indicated "Assessment completed, resident requires more assistance and encouragement, eat meals. Assistance of 2 caregivers and use of Hoyer for transfers, resident may pivot transfer to and from toilet using handrails, right heel, erythema present on left heel. ProCare boots to be applied continuously except for skin checks. Protective arm sleeves to be worn continuously except for skin checks, open skin tear to left forearm. Resident does enjoy music, requires morning and afternoon rest time elevating BLE in recliner. BS have been stable." R3 R3 was admitted to the licensee and began receiving services on May 18, 2022. R3's diagnoses included major depressive disorder and irritable bowel syndrome. R3's Service Plan signed May 19, 2022, indicated R3 received assistance with bathing, dressing, laundry, medication administration, and vital signs.	01620		

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01620	Continued From page 24 R3's record included a Clinical Update Assessment "reason: 90 days assessment" dated December 15, 2022, and was completed by LPN-C. R3's record also included a Clinical Update Assessment "reason: annual" dated June 19, 2023, completed by LALD/RN-A. R3's record lacked RN conducted ongoing reassessment and monitoring from the last assessment dated December 15, 2022, to the most recent assessment date of June19, 2023. R4 R4 admitted to licensee on April 27, 2023, and began receiving assisted living services. R4's diagnoses included Parkinson's disease, hypertension, diabetes, and dysphagia (difficulty swallowing). R4's Service Plan signed April 27, 2023, indicated R4 received assistance with bathing, meals, dressing, grooming, vital signs, laundry, blood glucose, and medication administration, R4's record included an admission assessment dated May 5, 2023, completed by LALD/RN-A, and a clinical update assessment "14 days assessment" dated May 10, 2023, completed by LPN-C. R4's record lacked evidence the RN conducted resident reassessment and monitoring as required. On July 25, 2023, at 4:02 p.m., LALD/RN-A stated she does initial assessments (admission), change of condition, and annual assessments, and LPN-C does 14-day and every 90-day clinical update. LALD/RN-A verified R2, R3, and R4's 14-day and 90-day assessments were completed by LPN-C. Also, LALD/RN-A acknowledged R2	01620		

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01620	Continued From page 25 had change of condition and the RN did not complete an assessment. The licensee's Initial And Ongoing Nursing Assessment Of Residents policy dated August 1, 2021, indicated "A RN will complete the following comprehensive assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-days assessment: completed up to 14 days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide medication storage per manufacturer's instructions when a medication refrigerator temperature was not monitored. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 26 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2023, at approximately 11:40 a.m., the medication refrigerator in the nurse's office was observed with licensed practical nurse (LPN)-C. A thermometer inside the medication refrigerator was confirmed by LPN-C to be 10.5 degrees Celsius (C), or approximately 51 degrees Fahrenheit (F). LPN-C stated the medication refrigerator was checked and monitored daily to ensure the temperature was in the recommended range. LPN-C stated the refrigerator temperature log was maintained in the licensee's electronic records. The medication refrigerator contained one unopened box of Novolog (short-acting) insulin flexpens (a multiple dose pen shaped injector device used for insulin administration) containing three pens. The manufacturer's instructions for Novolog insulin flexpens dated April 28, 2021, indicated before opening, store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze. On July 25, 2023, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated overnight staff monitored the medication refrigerator daily and entered the temperatures in the licensee's electronic record; however, she was unable to retrieve the information. Also, LALD/RN-A stated they will	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35978	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS OF LIFE LLC	6700 EGAN DRIVE SAVAGE, MN 55378

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01880	Continued From page 27 assign the task for nurses to monitor refrigerator temperature log and will re-educate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 the document review and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	02040		

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02040	Continued From page 28 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 clients). The findings include: On July 25, 2023, from 1:15 p.m. to 2:45 p.m., survey staff toured the facility with the owner (O)-E. On July 25, 2023, at approximately 3:15 p.m., a documentation review and interview were performed with the O-E relating to the memory care site-specific safety risk/vulnerability assessment and mitigation plan, indicating the licensee had not yet developed a memory care site-specific safety risk assessment and mitigation plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. No plan was provided or available for review. The findings were confirmed during the interview with the O-E that the licensee lacked the memory care site-specific provisions. July 25, 2023, at approximately 3:30 p.m., during the exit interview, O-E acknowledged the above findings. Survey staff discussed the findings and explained that all potential safety risks and/or vulnerabilities site-specific to memory care residents on and around the property need to be identified, assessed, mitigated, and documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35978	A. BUILDING: _____ B. WING _____	07/27/2023

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02040	Continued From page 29 (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35978	A. BUILDING: _____ B. WING _____	07/27/2023

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02110	Continued From page 30 move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were developed and provided to residents and/or the residents' legal and/or designated representatives at the time of move in for three of three residents (R2, 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) 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 has a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021. The licensee failed to develop and provide dementia policies and procedures for R2, R3 and R4 and all residents residing at licensee that addressed: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35978	A. BUILDING: _____ B. WING _____	07/27/2023

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02110	Continued From page 31 detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and drills only; - transportation coordination and assistance to and from outside medication appointments; and - safekeeping of resident's possessions. On July 26, 2023, at 3:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee did not develop and implement the required policies and procedures for the assisted living facility with dementia care licensee or provide them at the time of move-in to residents and/or their representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *07/24/23*
Time: 16:33:49
Report: 1018231128

Food and Beverage Establishment Inspection Report

Location:
Rivers Of Life Llc
6700 Egan Drive
Savage, MN55378
Scott County, 70

Establishment Info:
ID #: 0038077
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528558665
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE A MAXIMUM TEMPERATURE REGISTERING THERMOMETER FOR THE HIGH TEMP DISHWASHER. COMPLY WITH RULE.

Comply By: 08/31/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Type: Full
Date: *07/24/23*
Time: 16:33:49
Report: 1018231128
Rivers Of Life Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

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

INSPECTION CONDUCTED WITH SAFIA HASSAN (MDH) PRESENT.

ESTABLISHMENT USES ALL PRE-COOKED MEATS AND PASTEURIZED EGGS.

DISCUSSED EMPLOYEE ILLNESS AND PEST CONTROL.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018231128 of 07/24/23.

Certified Food Protection Manager: SUSAN M WEINZLERL

Certification Number: FM104546 Expires: 11/05/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
SUSAN M WEINZLERL

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us