DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 23, 2022

Licensee
Rivervillage East
2919 Randolph Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL23147015

Dear Licensee:

On December 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 12, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Electronically Delivered

November 15, 2022

Administrator
Rivervillage East
2919 Randolph Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL23147015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 12, 2022, 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.

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. 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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23147	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVILLAGE EAST	2919 RANDOLPH STREET NE MINNEAPOLIS, MN 55418

(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 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: SL23147015 On October 10, 2022, through October 12, 2022, 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 50 residents receiving services under the provider's Assisted Living Facility with Dementia Care license. On October 11, 2022 at 5:00 p.m. an immediate order was issued for 2310. On October 12, 2022, at 12:25 p.m. the immediacy of 2310 was removed, the scope and level will remain the same.	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 Facilities with Dementia Care. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 10, 2022, at 11:30 a.m., the executive director was identified as LALD-C for the licensee. On October 10, 2022, at 11:30 a.m. the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-C held a current assisted living director license. The BELTSS website did not indicate LALD-C was listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On October 12, 2022, at 12:00 p.m. LALD-C verified they were not listed as the Director of Record for licensee and would contact BELTSS for correction. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of four 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	0 630		

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0 630	Continued From page 3 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 had diagnoses include, but were not limited to, late onset Alzheimer ' s disease with behavioral disturbance, hypertension, and type two diabetes. R2's registered nurse (RN) Comprehensive Assessment - IAPP dated August 11, 2022, indicated R2 had vulnerabilities to include (not all inclusive): inability to manage finances, and disruptive behavior. R2's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. R3 R3 had diagnoses to include but were not limited to respiratory failure (a serious condition that makes it difficult to breathe on your own). R3's RN Comprehensive Assessment - IAPP dated September 29, 2022, indicated R3 had vulnerabilities to self-abuse. R3's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. On October 11, 2022, at 2:15 p.m. (RN)-A verified R2 and R3's IAPP lacked statements of the specific measures to be taken to minimize the	0 630		

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0 630	Continued From page 4 risk of abuse to R2 and R3. The Licensee's Individual Abuse Prevention Plans policy dated August 1, 2021, indicated resident IAPP would include specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 tenant 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	0 680		

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0 680	Continued From page 5 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect the licensee's residents, staff, and guests. 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: The licensee's emergency preparedness plan (EP), lacked the following required content: - Develop and maintain EP program; - Maintain and annual EP updates; - EP program patient population; - Process for EP collaboration; - Development of EP policies and procedures; - Subsistence needs for staff and patients; - Procedures for tracking of staff and patients; - Policies and procedures for sheltering; - Policies and procedures for medical documents; - Policies and procedures for volunteers; - Arrangement with other facilities; - Roles under a waiver declared by Secretary; - Development of communication plan;	0 680		

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0 680	Continued From page 6 - Emergency officials contact information; - Primary/alternate means for communication; - Methods for sharing information; - Sharing information on occupancy/needs; - LTC family notifications; - Emergency prep training and testing; - Emergency prep training program; - Emergency prep testing requirements; - LTC emergency power (typically engineering); and - Integrated health systems. On October 10, 2022, at 10:50 a.m. licensed assisted living director (LALD)-C stated the licensee's EP lacked the required content listed above. The licensee's Emergency Disaster Plan policy dated August 1, 2021, indicated licensee would have a written 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. The policy lacked the emergency preparedness verbiage to include content above. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

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0 800	Continued From page 7 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 occupied 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 October 11, 2022, approximately from 11:00 a.m. to 1:30 p.m., survey staff toured the facility with the maintenance technician (M)-F. During the facility tour, survey staff observed the following: 1) Extension cords were used in resident apartments 201, 301, 305, and 417. The use of unapproved extension cords posed a potential electrical fire hazard from overloading the electrical circuits. 2) In resident room 300, heavy stained carpet was observed in the living room area. 3) The fire-rated door to the maintenance workshop was wedged open. In addition, the	0 800		

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0 800	Continued From page 8 continuous opening of the door lead to unauthorized entries and posed safety concerns from misuse and exposure to chemicals and sharp objects. 4) The installation of the chemical soap dispenser connected to the faucet of the mop sink located in the 2nd-floor housekeeping room was not protected with the proper backflow protection, creating a risk of backflow of chemicals into the potable water supply. On October 11, 2022, at approximately 2:00 p.m., the M-F and the licensed assisted living director-C acknowledged the findings during the exit interview. No Further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 9 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 record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 10 On October 11, 2022, at approximately 1: 30 p.m., survey staff received and reviewed the fire safety and evacuation documentation, the evacuation drill records, and the training documentation provided by the licensed assisted living director (LALD)-C and the maintenance technician (M)-F. FIRE SAFETY AND EVACUATION PLAN 1) The plan documentation, effective date of 2/2012 with a review date of 9/2022, lacked complete fire protection procedures that included employee actions to be taken in the event of a fire or similar emergency. In addition, the documentation did not have the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique situations that must be considered during an evacuation include residents with mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. 2)The plan documentation lacked fire protection procedures for residents. DRILLS Documentation review indicated fire safety and evacuation drills performed by employees did not meet the minimum frequency required for employee fire safety and evacuation drills consisting of at least twice per year per shift and at least one evacuation drill every other month. Drill records provided for the review were 9/30/2021 (5:30 a.m.), 3/31/2022 (11:00 a.m.), 5/31/2022 (3:15 p.m.), and 8/1/2022 (5:45 a.m.) which did not meet the minimum required drill frequency. Survey staff explained to M-F and the	0 810		

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0 810	Continued From page 11 LALD-C that they need to adopt a policy to ensure a minimum required number of employee fire safety and evacuation drills will be performed and maintain records to show compliance with the requirement. TRAINING 1) Document review indicated the licensee lacked policy and records of employee training specifically on the fire safety and evacuation plan. No training records were available for review for compliance with employee training on fire safety and evacuation training required at minimum upon hire and twice a year, thereafter. 2) Document review indicated that the licensee did not provide annual training to residents who can assist in their evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. No training records were provided for review. On October 11, 2022, at approximately 2:00 p.m., the LALD-C and the M-F acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 12 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of seven residents (R3). 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 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:	01650		

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01650	Continued From page 13 R3's record included prescriber order dated April 12, 2022, which directed continuous Oxygen 2 liter via NC (nasal cannula) to help breathing. R3's diagnoses included but were not limited to respiratory failure (a serious condition that makes it difficult to breathe on your own). R3's Service Plan Agreement dated June 30, 2022, indicated R3 received services to include assistance with shower, and housekeeping. R3's record lacked evidence of a treatment plan for the use of oxygen. On October 11, 2022, at 9:30 a.m. R3 was observed lying in bed. There was an oxygen concentrator on and operating in the room. R3 stated staff assisted her with oxygen. On October 04, 2022, at 11:00 a.m. registered nurse (RN)-A stated resident service plans should include all services provided by the licensee, including the treatment for oxygen use. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 14 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for three of four	01730		

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01730	Continued From page 15 residents (R1, R2, 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: R1 On October 11, 2022, at 7:30 a.m. the surveyor observed ULP-F administer medications to and checked blood glucose for R1. R1's Service Plan dated January 14, 2021, indicated R1 received services including medication administration, bathing/hygiene/grooming, and yearly nursing assessment. R1's prescriber orders dated March 9, 2022, indicated R1 received medications to include: aspirin 81 milligram (mg) one tablet by mouth daily, glipizide 5 mg tablets twice daily, memantine hcl 10 mg tablets twice daily by mouth, and metformin hcl 500 mg tablet take two tablets twice daily. R2 R2's Service Plan dated July 19, 2022, indicated R2 received services including medication administration, annual review, and 90-day comprehensive assessment. R2's prescriber orders dated March 9, 2022, indicated R2 received medications to include:	01730		

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01730	Continued From page 16 acetaminophen 500 mg tablet take 1-2 tablets by mouth three times a day as needed, amlodipine 5 mg tablet take one tablet by mouth daily bupropion 300 mg tablet take one tablet by mouth daily, melatonin 5 mg tablet take one tablet by mouth daily at bedtime and memantine hcl 10 mg tablets twice daily by mouth. R4 On October 11, 2022, at 8:00 a.m. the surveyor observed ULP-E administer medications and checked blood glucose for R4. R4's Service Plan dated July 27, 2021, indicated R4 received services including medication administration. R4's prescriber orders dated August 24, 2022, indicated R4 received medications to include: acetaminophen 500 mg tablet take 1-2 tablets by mouth three times a daily, chlorthalidone 25 mg take 1 tablet by mouth daily and famatodine 20 mg take one tablet by mouth daily. R1, R2 and R4's records lacked individual medication management plan with required content to include: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 17 - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 11, 2022, at approximately 12:15 p.m., registered nurse (RN)-A verified R1, R2 and R4's individual medication management plans lacked required content. RN-A also stated other residents may be missing the same content identified in R1, R2 and R4's plans. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, lacked the content included in individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure expired medications were disposed of, in addition licensee failed to ensure medications were labeled with legible information for one of four residents (R1). 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: On October 11, 2022, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to and checked blood glucose for R1. On October 11, 2022, at 8:00 a.m., the surveyor observed R1's medication cabinet and noted: - Trazodone HCL 50 milligram (mg) tablets, take 12.5 mg by mouth two times a day expired on July 29, 2022, and - melatonin 5 mg unlabeled. On October 11, 2022, at 10:00 a.m., registered nurse (RN)-A acknowledged R1's expired and unlabeled medications. RN-A stated the nurses check resident medication cabinets weekly and were responsible to remove expired and unlabeled medications. No further information was provided.	01890		

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01890	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	01940		

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01940	Continued From page 20 Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all the required content for three of three residents (R1, R2, 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). Findings include: R1 R1 had diagnoses to include spacitic diplegic cerebral palsy, muscle weakness, hypertension, type 2 diabetes and suicidal ideation. R1's service plan dated August 26, 2022, indicated R1 was receiving the following services; medication administration, blood glucose monitoring, and comprehensive nursing assessment. R2 R2 had diagnoses to include hypertension, and difficult breathing. R2's service plan dated August 26, 2022, indicated R2 was receiving the following services: medication administrations. R3 R3 had diagnoses included but were not limited to respiratory failure (a serious condition that makes it difficult to breathe on your own). R3's service plan dated June 30, 2022, indicated R3 received services to include assistance with oxygen treatment.	01940		

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01940	Continued From page 21 R4 R4 had diagnoses to include hypertension and diabetes. R4's service plan dated July 27, 2021, indicated R4 was receiving the following services; medication administrations and diabetic care. R1, R2, R3 and R4's treatment or therapy management plans lacked required content to include: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 4, 2022, at 12:45 p.m. registered nurse (RN)-A confirmed R1, R2, R3 and R4's records lacked individualized treatment or therapy management plans to include all the content above. The licensee's Medications and Treatments policy dated March 2021, indicated licensee would "ensure medications and treatments systems are in accordance with the Comprehensive Home Care regulations". The policy lacked language to address the specific requirements identified under 144G.	01940		

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01940	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
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	02110		

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02110	Continued From page 23 (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 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 provided to residents and the residents' legal and designated representatives at the time of move in for two of four residents (R1, 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: R1 had a diagnosis of late onset of Alzheimer's disease without behavioral disturbance. R2 had a diagnosis of late onset Alzheimer's disease with behavioral disturbance. R3 had a diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own). R4 had diagnoses to include hypertension and diabetes. The licensee failed to develop, implement, and	02110		

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02110	Continued From page 24 provide dementia policies and procedures for R1, R2, R3, R4 and all residents residing at licensee, that addressed: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy should be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provided detailed instructions to staff in the event a resident eloped; - 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 were 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 October 11, 2022, at 11:20 a.m. registered nurse (RN)-A, and licensed assisted living director (LALD)-C stated all the residents had not received the required 10 policies. No further information was provided TIME PERIOD FOR CORRECTION- Twenty-one (21) days	02110		

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RIVERVILLAGE EAST	2919 RANDOLPH STREET NE MINNEAPOLIS, MN 55418

(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 25	02310		
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 provide care and services according to acceptable health care standards, medical or nursing standards with bed rail devices, for two of four residents (R3, R7) who utilized bed rail devices. This practice resulted in issuance of an immediate order on October 11, 2022, at approximately 5:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings included: R3 R3's diagnoses included but were not limited to respiratory failure (a serious condition that makes it difficult to breathe on your own). R3's service plan dated June 30, 2022, indicated R3 received services to include assistance with shower, housekeeping, and oxygen treatment.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23147	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVILLAGE EAST	2919 RANDOLPH STREET NE MINNEAPOLIS, MN 55418

(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 26 R3's RN Comprehensive Assessment dated September 29, 2022, indicated R3 was independent with ambulation/mobility and getting in and out of bed. R3's Bedrail assessment dated September 29, 2022, indicated bed rail was recommended to assist R3's turning from side to side and pain. On October 11, 2022, at 9:30 a.m. R3 was observed lying in bed. R3 stated she used the bed rails to reposition herself in bed. R3 stated she would also grab onto it when sitting up at the side of bed and when getting out of bed. R3 stated she was okay with the bed. When R3 mattress was lifted, it revealed the rail was one piece not bolted or otherwise not secured to the bed frame; the side rail was stabilized by the weight of the mattress. When the surveyor grasped the side rail, it easily moved side to side. R7 R7's diagnoses included, but were not limited to diabetes type II with diabetic (an impairment in the way the body regulates and uses sugar [glucose]), chronic congestive heart failure and hypertension. R7's service plan dated August 26, 2022, indicated R7 received services to include: 90-day monitoring and assessment, vital signs, bathroom assistance, shower assistance, dressing assistance, safety check, and medication administration. R7's Bedrail Assessment dated March 24, 2022, identified R7 was alerted but "declining" in cognition, R7 requested the bedrail device for "safety, security and turning from side to side." On October 11, 2022, at approximately 11:36	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23147	A. BUILDING: _____ B. WING _____	10/12/2022

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RIVERVILLAGE EAST	2919 RANDOLPH STREET NE MINNEAPOLIS, MN 55418

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02310	Continued From page 27 a.m. R7 stated the bed rails was working fine, and did not need any adjustment as she was happy with it. On October 11, 2022, at approximately 11:45 a.m. and 11:40 a.m. while observing the bed rail device on R3 and R7's bed, registered nurse (RN)-F was observed to move the device back and forth and verified the devices were loose. The RN verified the bed rail devices were held in place by the weight of the mattress. The portable bed rails were one piece measuring approximately 20 inches in width by 10 inches in height from the frame of the bed to the top of the bedrail and did not have any vertical bars. RN-F also verified the bed rails could easily be moved back and forth and were not secured to the bed frames. In addition, RN-F stated the resident families were responsible to install bed rails and when licensee nurses discover them, they complete assessments. RN-F stated the nurses failed to ensure R3 and R7's bed rails were installed according to manufacturer's instruction. On October 11, 2022, at 12:20 p.m. registered nurse (RN)-A provided Manufacturer's instruction"Bed Handle, Inc. Bedside assistant Bed Handle use, Assembly and Installation instruction model BA10W," date May, 2014. RN-A stated they had not referred to or reviewed manufacture instructions/guidelines when completing assessments or providing "risk benefit" to residents. - Page one of the instructions included in large print "! WARNING: SUFFOCATION AND STRANGULATION HAZARD. Gaps in and around the handle can entrap and kill" warning of increased risk with dementia, or those who are "sedated, confused, or frail, are at increased risk of entrapment."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23147	A. BUILDING: _____ B. WING _____	10/12/2022

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02310	Continued From page 28 - The instructions next directed, "ALWAYS use safety retention straps to properly secure handle. Incorrect installation can allow bed handle to move away from the mattress, which can lead to entrapment. NEVER use unless bed handle is tight against mattress and at least 12 ½" (inches) from headboard and foot board." "Stop using immediately if damaged, broken or if parts are missing." - The "! CAUTION:" section further advised, "Closely monitor the user's needs assessed and reassessed as needs may change. Always seek advise of professionals experienced in user needs and minimizing risks." -The next section identified "! IMPORTANT! KEEP FOR FUTURE REFERENCE! Read these instructions before using your bed handle. Failure to follow these instructions could result in serious injury or death." The Instructions included detailed directions for affixing the handle with straps to the bed frame, including photos of the device components, such as safety retention straps. - The "CARE AND MAINTENANCE" section directed to periodically check safety retention straps to make sure they were tight, secure leaving no gaps. The section further directed, "Do Not use if any part is missing or damaged." On October 11, 2022, at 12:28 p.m. the Consumers Product Safety Commission dated September 17, 2015, indicated, "Recall of Adult Portable Bed Handles Due to Serious Entrapment and Strangulation Hazards. When attached to an adult's bed without the use of safety retention straps, the handle can shift out of place, creating a dangerous gap between the bed handle and the side of the mattress. This poses a serious risk of entrapment, strangulation, and death".	02310		

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02310	Continued From page 29 The FDA, A Guide to Bed Safety, revised July 01, 2022, included the following information: "When bed rails are used, perform an on-going assessment of the patient's (resident'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." The licensee's Devices and Device Assessment policy, revised on November 18, 2015, indicated "Grab bars that either placed/attached or strapped between the matters and box spring or bed frame are not allowed in our building. If the facility staff learn of device like this on a bed it will be removed and alternative will be discussed with resident/responsible party, and for non- hospital beds: Devices will be installed according to manufacturer's instruction. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On October 12, 2022, at 12:25 p.m. the immediacy of 2310 was removed, the scope and level will remain the same.	02310		

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

Type: Full
Date: *10/10/22*
Time: 08:40:26
Report: 1018221159

Food and Beverage Establishment Inspection Report

Location:
Rivervillage East
2919 Randolph Street Ne
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:
ID #: 0038663
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126052500
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

SMARTPOWER: = 700PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

SMARTPOWER: = 700PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

SMARTPOWER: = 700PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Food and Equipment Temperatures

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

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

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

Process/Item: Hot Holding/ RICE
Temperature: 173 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Type: Full
Date: *10/10/22*
Time: 08:40:26
Report: 1018221159
Rivervillage East

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding/ VEGETABLES
Temperature: 171 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

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

INSPECTION CONDUCTED WITH HRD STAFF PRESENT.

VIEWED ILLNESS LOG AND DISCUSSED ILLNESS POLICY.

DISCUSSED PEST CONTROL AND CLEANING FREQUENCIES FOR THE FACILITY.

FIRM USES PRE-COOKED MEATS AND PASTEURIZED EGGS.

ALL EQUIPMENT PRESENT WAS COMMERCIAL GRADE EQUIPMENT.

NO ORDERS ISSUED.

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 1018221159 of 10/10/22.

Certified Food Protection Manager: NORMA J HILL

Certification Number: FM45113 Expires: 07/08/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
MIKE LENGELING
MANAGER

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