Electronically Delivered

March 6, 2024

Licensee
Riverside Assisted Living
812 Centre Street East
Royalton, MN 56373

RE: Project Number(s) SL30537015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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 MDH within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30537	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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: SL30537015-0 On February 20, 2024, through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 residents, 12 receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-F was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 20, 2024, at 2:52 p.m., the BELTSS website indicated LALD-F currently held a LALD license effective through October 31, 2024; however, LALD-F was not listed as the Director of Record for the licensee. On February 20, 2024, at 2:45 p.m., the surveyor observed the BELTSS website with assisted living director in residency (ALDIR)-B, and ALDIR-B said LALD-F was not listed as the director of record. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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

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0 485	Continued From page 4 The findings include: The licensee's Assisted Living Contract, page 17 and 18 of 22, Attachment C: Meal Plan Addendum noted the following meal plan options: - "Residents can choose to participate in the Community's monthly meal plan, which provides 3 meals per day" and noted the cost of the monthly meal plan was included in the daily rate; and - "Residents can choose to opt out of the Community's monthly meal plan. In that case, no meals would be provided" and noted the cost to opt out was a monthly rate reduction of $100. On February 22, 2024, at 1:10 p.m., assisted living director in residency (ALDIR)-B and licensed assisted living director (LALD)-F stated residents were offered "all or nothing" with meals, and did not have an option to select anything else. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 5 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of a completed health history and symptom screening for one of three employees (clinical nurse supervisor/CNS-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The Facility TB Risk Assessment form dated July 18, 2023, indicated the facility was at a low risk for TB transmission. In addition, it noted the site director was responsible for maintaining the TB screening records. CNS-A was hired on August 31, 2021, to provide direct care and services to the licensee's residents and oversight of the licensee's	0 660		

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0 660	Continued From page 6 employees. CNS-A's record contained a T-SPOT.TB dated September 16, 2021. However, the record lacked evidence of a completed TB history and symptom screening. On February 22, 2024, at 1:15 p.m., assisted living director in residency (ALDIR)-B and licensed assisted living director (LALD)-F stated CNS-A's records were kept in the management company's office, and they would check for the history and symptom screen. However, no further information was provided. The licensee's Tuberculosis & Staff Screening policy dated revised June 17, 2022, noted new personnel would be screened for active signs of TB using the Baseline TB Screening Tool for Healthcare Workers (HCW). The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 7 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. In addition, the licensee failed to evaluate the missing resident plan at least quarterly. This had	0 680		

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0 680	Continued From page 8 the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with assisted living director in residency (ALDIR)-B on February 20, 2024, at 9:50 a.m., the surveyor observed the facility's layout including one level, with a common sitting room, kitchen, and dining area, and resident rooms on both ends. The licensee's Emergency Preparedness binder dated reviewed June 15, 2023, included a Hazard Vulnerability Assessment dated January 17, 2024. The EPP lacked the following required content: - policy and procedure to track the location of staff whether evacuated or sheltered in place; and - a communication plan that included the names and contact information for residents' physicians. On February 22, 2024, at 2:10 p.m., ALDIR-B and licensed assisted living director (LALD)-F stated they were unable to find the required content in the EPP. In addition, ALDIR-B stated the missing resident plan was reviewed annually, not quarterly. Per Assisted Living Facilities: Minnesota Rules	0 680		

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0 680	Continued From page 9 Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 10 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, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required staff training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 21, 2024, licensed assisted living director (LALD)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 11 FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "9.06 Fire Policy", dated 08/01/2021, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-F provided records of staff training on 7/25/2023. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 12 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 13 (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (clinical nurse supervisor/CNS-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-A was hired on August 31, 2021, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-A's record lacked documented evidence of the following required training: - review of the types of Assisted Living services	01470		

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01470	Continued From page 14 the employee would provide and the provider's scope of license; and - principles of person-centered planning and service delivery. On February 22, 2024, at 1:15 p.m., assisted living director in residency (ALDIR)-B and licensed assisted living director (LALD)-F stated they were unable to find these required training on the transcripts, and would check with the management company office. However, no further information was provided. The licensee's Orientation of Personnel & Content policy dated August 1, 2021, noted all personnel must complete the orientation to assisted living facility requirements prior to providing services to residents. It noted the orientation must include a review of the types of assisted living services the employee would be providing and the facility's category of licensure, and principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 15 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 16 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (clinical nurse supervisor/CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-A was hired on August 31, 2021, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-A's record lacked documented evidence of the following required annual training: - reporting maltreatment of adults or minors; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 17 disease, or related disorders; and - a review of the provider's policies and procedures. On February 22, 2024, at 1:15 p.m., assisted living director in residency (ALDIR)-B and licensed assisted living director (LALD)-F stated they were unable to find these required training on the transcripts, and would check with the management company office. However, no further information was provided. The licensee's Required Annual Training policy dated August 1, 2021, noted training elements must be included every 12 months, including effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents with dementia, Alzheimer's disease, or related disorders, and a review of the site's policies and procedures related to the provision of assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 18 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes and glaucoma. R2's Service Plan dated January 26, 2024, noted services including assistance with bed mobility, bathing, and medication administration. R2's prescriber orders dated February 18, 2024, included Myrbetriq (a medication used to treat overactive bladder) 24 hour tablet 50 milligrams (mg) orally daily in the morning. R2's February 2024 Med (Medication) Admin (Administration) Summary noted the following: - Myrbetriq ER 50 mg tablet daily, with	01760		

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01760	Continued From page 19 instructions to "Give 1 capsule (60 mg) by mouth at bedtime. On February 22, 2024, at 8:41 a.m., clinical nurse supervisor (CNS)-A stated this was a transcription error, and it should note 50 mg instead of 60 mg. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel,	01790		

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01790	Continued From page 20 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP)	01790		

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01790	Continued From page 21 providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 20, 2024, at 9:15 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Management: Planned & Unplanned Time Away LOA (leave of absence) policy dated revised April 14, 2022, noted for unplanned time away when a pharmacist or licensed nurse was not available, the RN could delegate this task if RN had developed written procedures including how the RN should be notified that medications had been provided to the resident or resident's representative and whether the RN needed to be notified prior to the medications being given, and a review by the RN of the completion of the task to verify it was completed accurately by the ULP. The provided Medications: Resident LOA with Medications procedure, undated, lacked the following: - how the registered nurse shall be notified that medications have been provided and whether the	01790		

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01790	Continued From page 22 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; and - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel. On February 22, 2024, at 1:59 p.m., CNS-A stated staff notified the nurse prior to sending medications with a resident, and the RN reviewed it after it was completed, but these two steps were not included in the written procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02310 SS=D	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 facility failed to develop and implement new interventions related to the root cause of falls for two of two 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, but was not likely to	02310		

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02310	Continued From page 23 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: R1's diagnoses included cerebral vascular accident (stroke). On February 22, 2024, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-D provide catheter cares to R1 in his room. R1's Service Plan dated November 1, 2023, noted services including assistance with ambulation, leg brace, bed mobility, catheter care, toileting, and medication administration. R1's incident reports noted the following: - November 26, 2023, at 3:20 p.m., R1 was found on the floor in his room, and said he was transferring himself to bed and slipped. The report noted a fall risk tool had been updated, education provided to staff regarding the incident, and a follow up note was placed in the resident chart, assessment completed if the resident required changes to services. Sections asking if cause of fall was determined and interventions were left blank. Registered nurse (RN) progress note dated November 27, 2023, noted R1 had a fall on November 26, 2023, while self-transferring from wheelchair to bed. No shoes and only socks and AFO (foot brace). It noted no injuries and not increase pain reported. Education provided to resident on importance of using call light for assistance with transfers. Staff reported they think the brace slipped causing the fall. R1 stated he understood, but was still noted to self-transfer	02310		

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02310	Continued From page 24 after the conversation. Continue safety checks. - December 12, 2023, at 3:25 p.m., R1 was found on the floor in the hallway. R1 denied injury. It noted a fall risk tool had been updated, a progress note was made in the residents chart, it noted the service plan and individual abuse prevention plan had been reviewed. It noted education had been provided to staff. Sections asking if cause of fall was determined and interventions were left blank. RN progress noted dated December 15, 2023, noted recent falls were reviewed. One was from self-transferring and the other was from sliding too far on the cushion while in his wheelchair. Resident educated on importance of using his call light for assistance with transfers, and he stated he understood but was noted to self-transfer after the conversation. Continue safety checks. - January 16, 2024, at 12:15 p.m., R1 was found on the floor after trying to self-transfer to bed from the wheelchair. It noted a fall risk tool had been updated, a progress note had been made, and the service plan and individual abuse prevention plan had been reviewed. Sections asking if cause of fall was determined and interventions were left blank. RN progress note dated January 19, 2024, noted recent fall was reviewed, and R1 had a fall transferring independently from wheelchair to his bed. R1 only wearing brace and socks. Resident educated on importance of using his call light for assistance with transfers. R1 stated he understood, but still was noted to self-transfer after the conversation. Continue safety checks. - January 25, 2024, at 4:45 p.m., R1 was found on the floor in his room next to a transfer surface. It noted R1 had leaned forward in his wheelchair	02310		

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02310	Continued From page 25 and fell. R1 sustained bruises from on his back from the fall. It noted a fall risk tool had been updated, a progress note had been made, and the service plan and individual abuse prevention plan had been reviewed. Sections asking if cause of fall was determined and interventions were left blank. RN progress note dated January 26, 2024, noted R1 had been sick in bed all day, feeling tired. Provider updated that R1 had two falls the previous day, and harder time transferring. MD response was if daughter did not want him evaluated, to continue to monitor temperature, oxygen, and lungs/breathing and should be evaluated if worsening. - January 28, 2024, at 9:50 p.m., R1 was found on the floor and said he had slipped out of bed onto the floor. It noted a fall risk tool had been updated, a progress note had been made, and the service plan and individual abuse prevention plan had been reviewed. Sections asking if cause of fall was determined and interventions were left blank. RN progress note dated January 30, 2024, noted review of two recent falls resulting into sliding onto his bottom. One out of bee, and one out of the wheelchair. Educated resident on the importance of using his call light for assistance with transfers. R1 stated his understanding but was noted to still self-transfer after the conversation. Continue safety checks. - January 30, 2024 assessment completed noted as the 90 day clinical update, indicated staff were to assist R1 with all transfers using a gait belt and R1 had a history of refusing assistance and self-transferring. Bed mobility noted R1 required assistance to sit up in bed. Mobility noted as slightly limited in ability to change and control body position. It noted decreased muscular coordination, and due to diagnoses of a traumatic	02310		

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RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

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02310	Continued From page 26 brain injury (TBI) and stroke, confusion was noted. It noted mild confusion under mental status, and a memory problem. Fall risk summary was noted to be a score of 9 on the Missouri Alliance for Home Care Fall Risk Assessment Tool (MAHC), which indicated a fall risk with a score of 4 or more out of 10. It noted "Resident is at risk for falls as indicated by fall risk assessment score related to age, diagnosis, medications, and history of falls. Resident wears pendant call system around neck, and is able to appropriately use this to call for assistance as needed. PT [physical therapy] will be initiated PRN [as needed]." On February 22, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated interventions related to falls include on November 26, 2023, R1 was reminded to use his call light and safety checks were continued. December 12, 2023, fall R1 had two falls, one in the morning and one in the afternoon. Resident was educated to use the call light with transfers but continued to self-transfer after this. Safety checks were continued. CNS-A stated R1 has a diagnosis of dementia and with his stroke, she is not sure if his cognition is effected. CNS-A stated they had been talking with R1's daughter about using alarms, but she is not wanting to pay for them, so they are discussing paying for them as a facility. R1 is maybe impulsive and does not think to wait, but just gets up and goes on his own. January 16, 2024, noted to continue safety checks and education provided, with no new interventions. January 15, 2024, information was sent to R1's provider. R1 had two falls and was stiffer and had sustained bruises. Had a low grade temperature. Noted to continue safety checks and monitor. In addition, CNS-A stated routine safety checks were completed every two hours.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30537	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	812 CENTRE STREET EAST ROYALTON, MN 56373

(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 27 The January 28, 2024, fall CNS-A stated they provided education and continued safety checks. On February 12, 2024, CNS-A stated she emailed R1's daughter asking to remove the plastic under his bed (placed for complaints by the daughter of urine smell) which they felt may be contributing to the falls, and this was changed to plastic like you would put under your office chair, but that has also been removed. They are still talking about bed alarms. February 18, 2024, CNS-A stated no new interventions had been put in place. The licensee's Fall Prevention & Management policy dated September 21, 2021, noted a fall risk assessment was completed on each resident on admission, annually, upon change of condition, and reviewed following a fall. It noted high risk to fall prevention strategies included considering physical therapy and balance training for residents with gait instability, functional limitations, or a fall within the prior 30 days (with a prescriber order), and an evaluation for placement to a higher level of care. It noted the RN evaluated fall data to measure and analyze the falls and reviewed potential contributing factors and follow-up actions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02310		

Minnesota Department of Health
Food, Pools & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/20/24*
Time: 12:00:00
Report: 6808241028

Food and Beverage Establishment Inspection Report

Location:

Riverside Assisted Living
812 Centre Street East
Royalton, MN56373
Morrison County, 49

Establishment Info:

ID #: 0030537
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
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.

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

PROVIDE PASTEURIZED EGGS FOR "MADE -TO -ORDER" EGGS THAT ARE OR MAY BE UNDERCOOKED.

Comply By: 02/21/24

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

Type: Full
Date: *02/20/24*
Time: 12:00:00
Report: 6808241028
Riverside Assisted Living

Food and Beverage Establishment Inspection Report

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 6808241028 of 02/20/24.

Certified Food Protection Manager: Jonelle Langer

Certification Number: _____ Expires: 06/23/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Lee Ann Austin
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us