



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

December 12, 2023

Licensee
Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431

RE: Project Number(s) SL32649015

Dear Licensee:

Please note: This letter amends the previous letter dated December 8, 2023. Specifically, this notice corrects the language referring to the state correction orders. There were orders related to the April 13, 2022, survey found not yet corrected during the follow-up survey conducted October 18, 2023.

On October 18, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 13, 2022. This follow-up survey determined your facility had **not** corrected all of the state correction orders issued pursuant to the April 13, 2022 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 13, 2022, found not corrected at the time of the October 18, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (a) / 626.557, Subd. 3
0730-Contents Of Resident Record-144g.43 Subd. 3
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violations noted at the time of this follow-up survey completed on October 18, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on October 18, 2023, we identified the following violation(s):

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer: at 320-223-7329.

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

Sincerely,

A handwritten signature in black ink that reads "Paul G. Spencer". The signature is written in a cursive, flowing style.

Paul Spencer, Supervisor
State Evaluation Team
Email: paul.spencer@state.mn.us
Telephone: 320-223-7329 Fax: 1-866-890-9290

HHH



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December 8, 2023

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To submit a reconsideration request, please visit:

<https://www.web.health.state.mn.us/form/HRD-Appeals-Form>

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer: at 320-223-7329.

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

Sincerely,



Paul Spencer, Supervisor
State Evaluation Team
Email: paul.spencer@state.mn.us
Telephone: 320-223-7329 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/18/2023
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(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 On October 16, 2023, through October 18, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for survey SL32649015-4. As per the Enforcement letter dated November 22, 2023, the conditonal license is lifted. The following correction order is issued: 0660. The following correction orders are re-issued: 0620, 0730, and 1620.	{0 000}	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been 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 requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 000}	Continued From page 1	{0 000}	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.		
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not Assessed	{0 115}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;	{0 250}			

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{0 250}	Continued From page 2 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or	{0 250}			

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{0 250}	Continued From page 3 (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Not assessed.	{0 250}		
{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: Not Assessed	{0 480}		
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury	{0 620}		

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{0 620}	Continued From page 4 which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	{0 620}			

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{0 620}	Continued From page 5 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) within 24-hours for two of four residents (R1 and 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) 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 R1's diagnoses included dementia and anxiety disorder. R1's service plan dated September 19, 2023, indicated R1 received behavior management for flight risk, used a wander guard, and had safety checks. R1's assessment dated September 19, 2023, indicated R1 needed an escort to meals and activities due to weakness and risk for falls, and was not safe to be out in the community alone due to blindness and cognitive impairment. One section of the assessment indicated R1 was at risk for elopement and had attempts of leaving the building. Another section of the assessment	{0 620}			

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{0 620}	Continued From page 6 indicated R1 wandered in other resident's rooms, had not wandered, or left the building, had attempted to go out the front door, and had been found standing at the front of the building entrance. R1's assessment dated October 3, 2023, indicated the same information. An incident report dated June 2, 2023, indicated R1 had a fall when he got outside the building and was found at the bank. The incident report indicated 911 was not called. The incident report indicated actions taken to prevent future falls were to increase safety checks, increased cameras in the facility, continue to search for alternative placement for R1, inquire about wander guard system, and flight risk behavior monitoring. A Minnesota Adult Abuse Reporting Center (MAARC) document provided by registered nurse (RN)-D indicated the June 2, 2023, incident was reported on June 6, 2023, at 1:56 p.m. A progress note dated July 20, 2023, at 10:58 a.m., indicated R1 had an episode in past week of walking outside of the building independently. The same document indicated staff member(s) were able to direct R1 back into the building without incident. The note indicated further information/investigation was pending. A progress note dated July 20, 2023, at 3:23 p.m., indicated R1 was standing outside the front door approximately 10 feet from the door. R1 told staff he was getting a different view and returned inside the building without issue. A progress note dated September 14, 2023, at 9:17 a.m., indicated R1 had an elopement attempt and was found in the entryway beyond	{0 620}			

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{0 620}	Continued From page 7 the first door. Staff redirected R1 back into the facility. An incident report dated September 28, 2023, indicated staff was alerted by the wander guard alarm R1 had left the building. R1 was found in the parking lot. A Minnesota Adult Abuse Reporting Center (MAARC) document provided by RN-A indicated the September 28, 2023, incident was reported on October 4, 2023, at 5:32 p.m. R2 R2's diagnoses included morbid obesity, depression, diabetes mellitus type 2, and congestive heart failure. R2's service plan last updated September 19, 2023, indicated R2 was vulnerable for mobility and transfers R2's assessment dated February 7, 2023, indicated R2 needed assistance for bed mobility and a mechanical lift EZ stand (stand-to-transfer assist device) to transfer due to weakness. This same assessment indicated R2 was non-ambulatory. A Minnesota Adult Abuse Report dated September 19, 2023, indicated the facility had called in a report of fall from lift and possibly two falls. These falls were to have happened back in February and/or March of 2023 and had not previously been reported or documented in the facility. An incident reported dated September 28, 2023, at 1:00 p.m., indicated that approximately six months beforehand facility staff member(s) transferred R2 with the EZ stand from bed to	{0 620}			

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{0 620}	Continued From page 8 wheelchair when the sling slipped from the machine and fell to the floor with R2 landing on his right side. The report indicated the nurse was notified, checked R2 for injuries, and a Hoyer lift was used to transfer resident from floor to bed. This same document indicated the EZ stand was missing a safety latch on the side that had released. The same document indicated this event should have been reported as a MAARC report at the time it occurred approximately six months later. An incident documentation form dated October 2, 2023, indicated on September 27, 2023, a staff member may have abused R2 by transferring him roughly. The same document indicated a staff member may abused a resident by yelling and swearing at him and threatening to withhold snacks. A Minnesota Adult Abuse Reported dated September 30, 2023, indicated an incident occurred on September 27, 2023, of suspected abuse. A review of R2's facility progress notes did not identify documentation regarding the incidents from February, March, nor September of 2023. During an interview on October 17, 2023, at 3:00 p.m., the assisted living director in residency (ALDIR), who is also a registered nurse, stated on admission she performed the first transfer with the facility EZ Stand (stand-assist lift) and a medium transfer sling. The ALDIR stated she completed the first transfer and completed an assessment at that time. The ALDIR stated the assessment was included in the comprehensive assessment. The ALDIR stated she was not aware of the missing clip on the stand during the	{0 620}			

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{0 620}	Continued From page 9 assessment. The ALDIR stated the facility used R2's weight provided by the discharging hospital. During the same interview, the ALDIR stated regarding the fall which occurred in February or March of 2023, she did not complete an incident report as she thought the unlicensed personnel (ULP) had completed one. The ALDIR stated the ULPs informed her of the fall [the facility employed her as a nurse during that time] and R2 was not injured and did not require medical attention. During the same interview, the ALDIR stated there was a recent event involving an ULP being rough during transfers, cursing at the resident, and threatening to withhold a snack. The ALDIR stated the incident happened on a Monday night and the ALDIR was told about it on Thursday and was not reported to MAARC until Saturday. The ALDIR stated one ULP stated it happened and one stated it did not. The ALDIR stated she did complete a MAARC report after she had been instructed to do so. During an interview on October 18, 2023 at 1:53 p.m., RN-A stated she started with the facility as a consultant in July 2023. RN-A stated that in September 2023 R2 told her about the two falls which had occurred in the past. RN-A stated R2 said one fall occurred while using the EZ stand when he fell to the ground and landed on his tailbone which caused him soreness. The other fall involved being lowered to the ground. RN-A stated when she reviewed R2's medical record she could not find documentation regarding these events nor that they had been reported to MAARC. RN-A stated she determined the first fall occurred around February 20, 2023. RN-A stated she determined the second fall occurred in March	{0 620}			

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{0 620}	Continued From page 10 2023 in which R2 "buckled" and needed to be lowered quickly to the floor. RN-A stated the facility did not have records or logs regarding equipment maintenance. RN-A stated she learned about the potential abuse of R2 after returning from a vacation and learned the alleged incident occurred a few days earlier. RN-A stated she contacted the ALDIR who said she had interviewed those involved but had not done a MAARC report. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, indicated the licensee educate staff how to report suspected maltreatment internally and to the MAARC. Staff who suspect maltreatment of a resident or who has knowledge of abuse, financial exploitation, neglect, or a resident who has sustained a physical injury which is not reasonably explained, are to take immediate action to protect, or keep safe, the resident affected. The policy indicated such report must be made no later than 24 hours after first suspected.	{0 620}			
{0 630} SS=F	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	{0 630}			

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{0 630}	Continued From page 11 self-abuse. This MN Requirement is not met as evidenced by: Not Assessed	{0 630}			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test, for one of three employees (licensed practical nurse (LPN)-B). This could affect all residents, staff members, and viistors.	0 660			

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0 660	Continued From page 12 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). Finding include: LPN-B LPN-B was hired on July 10, 2023. LPN-B's employee record included a document labeled "T-SPOT.TB" which indicated "a negative test result does not exclude the possibility of exposure to or infection with Mycobacterium tuberculosis." The document further indicated results from T-SPOT.TB testing must be used in conjunction with each individual's epidemiological history, current medical status, and results of other diagnostic evaluations." A review of LPN-B's employee record did not identify a baseline TB screening or testing for the presence of TB infection. During interview on October 16, 2023, at 12:45 p.m., registered nurse (RN)-A stated LPN-B did not have a baseline screening in her employee file. RN-A further stated she did not know what the T-SPOT.TB diagnostic document was. The licensee policy 8.16 Tuberculosis Screening, dated August 1, 2021, indicated staff whose essential job functions require work within the same air space of home care clients will be	0 660			

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0 660	Continued From page 13 screened and tested for tuberculosis prior to the staff being exposed to clients. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	{0 730}			

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{0 730}	Continued From page 14 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to ensure documentation of incidents involving the resident and actions taken in response to the needs of the resident were completed for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted on February 6, 2023. R2's diagnosis included morbid obesity, depression, diabetes mellitus Type 2, and congestive heart failure.	{0 730}			

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{0 730}	Continued From page 15 Review of R2's facility progress notes lack documentation of three incidents involving R2 which included two separate incidents relating to falls from the EZ Stand and one incident of verbal abuse from an unlicensed staff. During an interview on October 16, 2023, at 8:15 a.m., registered nurse (RN)-A stated occurrences and incidents are to be documented, investigated, interviews completed, and an appropriate action would follow. RN-A stated if the facility cannot make a determination within 24 hours a report will be sent into the Minnesota Adult Abuse Reporting Center (MAARC) and the facility would continue with their internal investigation. During an interview on October 16, 2023, at 12:45 p.m., assisted living director in residency (ALDIR)-D stated when R2 fell out of the EZ Stand a report was not completed as ALDIR-D understand the ULP who witnessed the fall would complete a report. Review of facility incident forms for R2 indicated no documentation had been completed and it was not until September 28, 2023, at 1 p.m. when a incident report was completed for fall from the EZ stand when transferring which occurred approximately the week of February 20, 2023. Review of facility incident forms for R2, indicated no documentation or incident report was completed for incident when resident slide out of the EZ stand sometime in March of 2023. Review of facility incident forms for R2, indicated on October 2, 2023, the ALDIR-D completed an incident documentation form for an alleged verbal abuse that occurred on September 27, 2023.	{0 730}			

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{0 730}	Continued From page 16	{0 730}			
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Not Assessed	{0 930}			
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information	{0 940}			

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{0 940}	Continued From page 17 (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Not Assessed	{0 940}			

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{0 940}	Continued From page 18	{0 940}			
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not Assessed	{01530}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	{01620}			

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{01620}	Continued From page 19 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure resident assessments provided clear directions for resident cares for two of three residents (R1 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	{01620}			

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{01620}	Continued From page 20 The findings include: R1 R1's diagnoses included dementia and anxiety disorder. R1's service plan dated September 19, 2023, indicated R1 received behavior management for flight risk, used a wander guard, and had safety checks. R1's assessment dated September 19, 2023, indicated R1 needed an escort to meals and activities due to weakness and risk for falls, and was not safe to be out in the community alone due to blindness and cognitive impairment. One section of the assessment indicated R1 was at risk for elopement and had attempts of leaving the building. Another section of the assessment indicated R1 wandered in other resident's rooms, had not wandered, or left the building, had attempted to go out the front door, and had been found standing at the front of the building entrance. R1's assessment dated October 3, 2023, indicated the same information. An incident report dated June 2, 2023, indicated R1 had a fall when he had gotten out of the building and was found at the bank. The incident report indicated 911 was not called. A progress note dated July 20, 2023, at 10:58 a.m., indicated R1 had an episode in past week of walking outside of the building independently. Staff were able to direct R1 back into the building without incident. A progress note dated July 20, 2023, at 3:23 p.m., indicated R1 was standing outside the front door approximately 10 feet from the door. R1 told staff he was getting a different view and returned	{01620}			

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{01620}	Continued From page 21 inside the building without issue. A progress note dated September 14, 2023, at 9:17 a.m., indicated R1 had an elopement attempt and was found in the entryway beyond the first door. Staff redirected R1 back into the facility. An incident report dated September 28, 2023, indicated staff was alerted by the wander guard alarm R1 had left the building. R1 was found in the parking lot. R4 R4's diagnoses included Diabetes Mellitus Type II and memory deficit. R4's unsigned service plan dated October 17, 2023, indicated R4 received flight risk behavior management, safety checks, and used a wander guard. R4's assessment dated August 28, 2023, indicated R4 walked independently with the use of a walker and needed escorts to meals and activities due to cognitive impairments. The assessment indicated R4 was at risk for elopement and had left the facility with her husband in April 2021, before he passed away. However, R4 asked about her husband and said she wanted to go home on May 15, 2023, and May 16, 2023, and asked about her vehicle on May 17, 2023. The assessment further indicated R4 does not wander throughout the facility and when she is escorted to an area, she usually stays there until staff escort her to another area. R4's progress note, dated September 6, 2023, at 1:09 p.m., indicated RN-A spoke with R4's family member to inform them R4 was at risk of elopement. RN-A told R4's family member they would be implementing the use of a wander	{01620}			

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{01620}	Continued From page 22 guard. During observation on October 16, 2023, at 1:00 p.m., R4 entered the office the surveyors were occupying, ambulating without a walker, and sat down in a chair at the table with the surveyors. R4 began having unintelligible (impossible to understand) conversation with the surveyors. R4 remained in the office for over 30 minutes before a staff member entered the office and took R4 down the hall to a music activity. Following the completion of the music activity R4 returned to the office, again ambulating without a walker, and sat down with the surveyors again. R4 was in the office for approximately 5 minutes before LPN-B entered the office and took R4 down the hall. During an interview on October 17, 2023, at 2:37 p.m., RN-D stated RN-D stated she did not complete either of R1's assessment. RN-D stated 95 % of the time R4 does not wander throughout the building. RN-D also stated she knew R4 came down to visit the surveyors yesterday. During an interview on October 18, 2023, at 1:50 p.m., RN-D stated about 95% of the time R4 stays with staff, only goes between the dining room and activity room. RN-D stated R4 really does not wander around the building. The licensee 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident.	{01620}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/18/2023
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
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{01940}	Continued From page 23 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: Not Assessed	{01940}			
{03000} SS=D	626.557 Subd. 3 DO NOT USE / Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has	{03000}			

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{03000}	Continued From page 24 been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common	{03000}			

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{03000}	Continued From page 25 entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: RE-ISSUE under 0620	{03000}			

Minnesota Department of Health

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{0 000}	Initial Comments On October 16, 2023, through October 18, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for survey SL32649015-4. As per the Enforcement letter dated November 22, 2023, the conditonal license is lifted. The following correction order is issued: 0660. The following correction orders are re-issued: 0620, 0730, and 1620.	{0 000}	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been 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 requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the Surveyors and/or Investigators ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys and/or complaint investigations. 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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 000}	Continued From page 1	{0 000}			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test, for one of three employees (licensed practical nurse (LPN)-B). This could affect all residents, staff members, and viistors.	0 660	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPY AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.		

Minnesota Department of Health

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0 660	Continued From page 2 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). Finding include: LPN-B LPN-B was hired on July 10, 2023. LPN-B's employee record included a document labeled "T-SPOT.TB" which indicated "a negative test result does not exclude the possibility of exposure to or infection with Mycobacterium tuberculosis." The document further indicated results from T-SPOT.TB testing must be used in conjunction with each individual's epidemiological history, current medical status, and results of other diagnostic evaluations." A review of LPN-B's employee record did not identify a baseline TB screening or testing for the presence of TB infection. During interview on October 16, 2023, at 12:45 p.m., registered nurse (RN)-A stated LPN-B did not have a baseline screening in her employee file. RN-A further stated she did not know what the T-SPOT.TB diagnostic document was. The licensee policy 8.16 Tuberculosis Screening, dated August 1, 2021, indicated staff whose essential job functions require work within the same air space of home care clients will be	0 660			

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0 660	Continued From page 3 screened and tested for tuberculosis prior to the staff being exposed to clients. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure resident assessments provided clear directions for	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 4 resident cares for two of three residents (R1 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R1's diagnoses included dementia and anxiety disorder. R1's service plan dated September 19, 2023, indicated R1 received behavior management for flight risk, used a wander guard, and had safety checks. R1's assessment dated September 19, 2023, indicated R1 needed an escort to meals and activities due to weakness and risk for falls, and was not safe to be out in the community alone due to blindness and cognitive impairment. One section of the assessment indicated R1 was at risk for elopement and had attempts of leaving the building. Another section of the assessment indicated R1 wandered in other resident's rooms, had not wandered, or left the building, had attempted to go out the front door, and had been found standing at the front of the building entrance. R1's assessment dated October 3, 2023, indicated the same information. An incident report dated June 2, 2023, indicated R1 had a fall when he had gotten out of the building and was found at the bank. The incident report indicated 911 was not called.	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 5 A progress note dated July 20, 2023, at 10:58 a.m., indicated R1 had an episode in past week of walking outside of the building independently. Staff were able to direct R1 back into the building without incident. A progress note dated July 20, 2023, at 3:23 p.m., indicated R1 was standing outside the front door approximately 10 feet from the door. R1 told staff he was getting a different view and returned inside the building without issue. A progress note dated September 14, 2023, at 9:17 a.m., indicated R1 had an elopement attempt and was found in the entryway beyond the first door. Staff redirected R1 back into the facility. An incident report dated September 28, 2023, indicated staff was alerted by the wander guard alarm R1 had left the building. R1 was found in the parking lot. R4 R4's diagnoses included Diabetes Mellitus Type II and memory deficit. R4's unsigned service plan dated October 17, 2023, indicated R4 received flight risk behavior management, safety checks, and used a wander guard. R4's assessment dated August 28, 2023, indicated R4 walked independently with the use of a walker and needed escorts to meals and activities due to cognitive impairments. The assessment indicated R4 was at risk for elopement and had left the facility with her husband in April 2021, before he passed away. However, R4 asked about her husband and said she wanted to go home on May 15, 2023, and	{01620}			

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{01620}	Continued From page 6 May 16, 2023, and asked about her vehicle on May 17, 2023. The assessment further indicated R4 does not wander throughout the facility and when she is escorted to an area, she usually stays there until staff escort her to another area. R4's progress note, dated September 6, 2023, at 1:09 p.m., indicated RN-A spoke with R4's family member to inform them R4 was at risk of elopement. RN-A told R4's family member they would be implementing the use of a wander guard. During observation on October 16, 2023, at 1:00 p.m., R4 entered the office the surveyors were occupying, ambulating without a walker, and sat down in a chair at the table with the surveyors. R4 began having unintelligible (impossible to understand) conversation with the surveyors. R4 remained in the office for over 30 minutes before a staff member entered the office and took R4 down the hall to a music activity. Following the completion of the music activity R4 returned to the office, again ambulating without a walker, and sat down with the surveyors again. R4 was in the office for approximately 5 minutes before LPN-B entered the office and took R4 down the hall. During an interview on October 17, 2023, at 2:37 p.m., RN-D stated RN-D stated she did not complete either of R1's assessment. RN-D stated 95 % of the time R4 does not wander throughout the building. RN-D also stated she knew R4 came down to visit the surveyors yesterday. During an interview on October 18, 2023, at 1:50 p.m., RN-D stated about 95% of the time R4 stays with staff, only goes between the dining room and activity room. RN-D stated R4 really does not wander around the building.	{01620}			

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{01620}	Continued From page 7 The licensee 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident.	{01620}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 1, 2023

Licensee

Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431

RE: Project Number(s) SL32649015

Dear Licensee:

On April 18, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 24, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 24, 2023, found not corrected at the time of the April 18, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) = \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 18, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on April 18, 2023, we identified the following violation(s):

0470-Minimum Requirements-144g.41 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer at 651-587-4460.

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

Sincerely,

A handwritten signature in black ink that reads "Paul G. Spencer". The signature is written in a cursive, flowing style.

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 651-215-6894

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/18/2023
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{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: #SL32649015 On April 18, 2023, the Minnesota Department of Health conducted licensing order follow-up related to correction orders issued for #SL32649015. At the time of the survey, there were 35 residents receiving services. The following correction orders are re-issued for #SL32649015, tag identification 0620, 0730, 0810,1620, and 3000. The following additional correction orders are issued for #SL32649015, 0470 and 0820. Please see the proceeding form.	{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 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 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.		
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are	{0 115}			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 115}	Continued From page 1 established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not assessed	{0 115}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	{0 250}			

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{0 250}	Continued From page 2 any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Not assessed.	{0 250}			

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0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop and implement a written staffing plan. 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	0 470			

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0 470	Continued From page 4 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 an interview on April 18, 2023, at 3:25 p.m., the registered nurse (RN)-A, also the director of nursing, stated the licensed assisted living director (LALD) had the staffing plan. RN-A stated the LALD was no longer working for the licensee and RN-A was unable to find the staffing plan. The licensee's staffing plan was requested but not provided for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Not assessed	{0 480}			
{0 620} SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of	{0 620}			

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{0 620}	Continued From page 5 maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) within 24-hours for one of nine residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4's diagnoses included dementia, glaucoma, and macular degeneration. R4's care plan dated March 24, 2023, indicated R4 was independent with ambulation with use of a walker. R4's Individual Abuse Prevention Plan (IAPP), dated March 24, 2023, indicated R4 had vision impairments, made poor decisions, was at risk for elopement, and had frequent safety checks. The document further indicated R4 felt he should be able to leave the facility on his own, made statements of not wanting to be at the facility, but had never attempted to leave the facility or property. R4's treatment assistance record (TAR), dated April 2023, indicated R4 was on hourly safety	{0 620}			

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{0 620}	Continued From page 6 checks. During observation on April 18, 2023, at 1:15 p.m., an unidentified staff (US) entered the registered nurses (RN)-A, also the director of nursing, office and informed her of an incident which had just occurred. The surveyor heard the US state they have him back in the building now. The surveyor went to the front lobby area and observed three staff standing around R4 while he sat in a chair near the front entrance. As the surveyor approached the area, R4 exited to the patio area to have a cigarette and staff left the area. During an interview on April 18, 2023, at 1:25 p.m., when the surveyor asked the unlicensed personnel (ULP)-B if she knew of a resident leaving the building a short time ago, ULP-B stated she was sitting outside when she noticed R4 had exited the facility and was walking in the parking lot. ULP-B stated she redirected R4 back into the facility. ULP-B also stated approximately four weeks ago, on a Saturday she was off work, she saw R4 at the gas station next door to the facility and brought him back to the facility. ULP-B stated she called RN-A to notify her of the incident. ULP-B further stated R4 goes out of the facility at least one time per week. ULP-B stated if she is the staff who redirects R4 back into the facility, she documents in R4's behavior notes or sends a message to RN-A or administration through the electronic medical record (EMR). Further review of R4's record did not identify any incident reports were completed for R4's April 18, 2023 incident or any other incidents stated during the interview with ULP-B. During interview on May 18, 2023, at 1:00 p.m.,	{0 620}			

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{0 620}	Continued From page 7 RN-A initially stated she recalled the incident when ULP-B was not working but found R4 at the gas station and brought him back to the facility one Saturday. RN-A then thought she had the incident mixed up with a different incident involving R4. However, later in the interview, RN-A stated it was very possible that specific Saturday incident occurred. RN-A stated R4 was exiting out the front doors but it was hard to know how often he was doing it. RN-A stated there were no incident reports in R4's record, but there should have been. The licensee's 2.25 Incident Report policy dated January 1, 2023, indicated any incident involving a resident must be reported to management and an incident report form should be completed to document what happened. The policy indicated all incident reports related to residents will be kept in their records. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2023, indicated the licensee educate staff how to report suspected maltreatment internally and to the MAARC. Staff who suspect maltreatment of a resident or who has knowledge of abuse, financial exploitation, neglect, or a resident who has sustained a physical injury which is not reasonably explained, are to take immediate action to protect, or keep safe, the resident affected. The policy indicated such report must be made no later than 24 hours after first suspected.	{0 620}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	{0 630}			

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{0 630}	Continued From page 8 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: Not assessed	{0 630}			
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	{0 730}			

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{0 730}	Continued From page 9 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure documentation of incidents involving the resident and actions taken in response to the needs of the resident were completed for one of nine residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	{0 730}			

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{0 730}	Continued From page 10 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: R4's diagnoses included dementia, glaucoma, and macular degeneration. R4's care plan dated March 24, 2023, indicated R4 was independent with ambulation with use of a walker. R4's Individual Abuse Prevention Plan (IAPP), dated March 24, 2023, indicated R4 had vision impairments, made poor decisions, was at risk for elopement, and had frequent safety checks. The document further indicated R4 felt he should be able to leave the facility on his own, made statements of not wanting to be at the facility, but had never attempted to leave the facility or property. R4's progress note, dated March 14, 2023, at 10:35 a.m. indicated R4 had been found in his room smoking a cigarette the evening prior. R4's smoking items were removed from his room, would be kept with staff, and provided to R4 when he is outside the facility. Staff will also assist R4 with lighting his cigarette. R4's progress note, dated March 15, 2023, at 2:17 p.m. indicated R4 had been more confused for the past four days. The note indicated R4 had been smoking in the facility, burning holes in his clothing while smoking, wandering into other resident's rooms during the night waking them from sleep and accusing them of taking his belongings. R4's progress note, dated March 16, 2023, at	{0 730}			

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{0 730}	Continued From page 11 4:00 p.m., indicated R4 had been going outside into the parking lot wandering, trying to get to the store. The note indicated it was clear R4 did not know how to get to the store. R4's progress note, dated March 16, 2023, at 5:12 p.m., indicated administration staff had a discussion with R4's family regarding a change in behaviors and the possibility of R4 needing to move to a secured facility. R4's progress note, dated March 16, 2023, at 5:37 p.m., indicated R4 had wandered into other residents' rooms, was unhappy he could not have his cigarettes, and wanted to go to the store on two separate occasions, once for cigarettes and once for juice. Staff members redirected him. R4's progress notes, dated between March 24, and April 5, 2023, included five entries indicating family and licensee administration were working on relocating R4 to a secured facility. R4's treatment assistance record (TAR), dated April 2023, indicated R4 was on hourly safety checks. During observation on April 18, 2023, at 1:15 p.m., an unidentified staff (US) entered the registered nurses (RN)-A, also the director of nursing, office and informed her of an incident which had just occurred. The surveyor heard the US state they have him back in the building now. The surveyor went to the front lobby area and observed three staff standing around R4 while he sat in a chair near the front entrance. As the surveyor approached the area, R4 exited to the patio area to have a cigarette and staff left the area	{0 730}			

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{0 730}	Continued From page 12 During an interview on April 18, 2023, at 1:25 p.m., when the surveyor asked the unlicensed personnel (ULP)-B if she knew of a resident leaving the building a short time ago, ULP-B stated she was sitting outside when she noticed R4 had exited the facility and was walking in the parking lot. ULP-B stated she redirected R4 back into the facility. ULP-B also stated approximately four weeks ago, on a Saturday she was off work, she saw R4 at the gas station next door to the facility and brought him back to the facility. ULP-B stated she called RN-A to notify her of the incident. ULP-B further stated R4 goes out of the facility at least one time per week. ULP-B stated if she is the staff who redirects R4 back into the facility, she documents in R4's behavior notes or sends a message to RN-A or administration through the electronic medical record (EMR). Further review of R4's record did not identify any incident reports completed for R4's April 18, 2023, incident or any other incidents stated during the interview with ULP-B. During interview on May 18, 2023, at 1:00 p.m., RN-A initially stated she recalled the incident when ULP-B was not working but found R4 at the gas station and brought him back to the facility one Saturday. RN-A then thought she had the incident mixed up with a different incident involving R4. However, later in the interview, RN-A stated it was very possible that specific Saturday incident occurred. RN-A stated R4 was exiting out the front doors but it was hard to know how often he was doing it. RN-A stated there were no incident reports in R4's record, but there should have been. The licensee's 2.25 Incident Report policy dated January 1, 2023, indicated any incident involving	{0 730}			

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{0 730}	Continued From page 13	{0 730}		
{0 810} SS=F	a resident must be reported to management and an incident report form should be completed to document what happened. The policy indicated all incident reports related to residents will be kept in their records. 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	{0 810}		

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{0 810}	Continued From page 14 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required evacuation drill frequency. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at approximately 12:10 p.m., the maintenance manager (MM)-E provided documents for review. Documentation was requested for evacuation drills completed since the last survey. A fire and evacuation drill schedule for 2022 was included but a schedule for 2023 was not provided. Documented drills for 2023 were dated 1/12/2023 and 04/08/2023. Documentation to support the evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On April 24, 2023, at approximately 12:20 p.m., MM-E verified this deficient condition. No further information was provided.	{0 810}			

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{0 820}	Continued From page 15	{0 820}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, between 11:50 a.m. and 12:10 a.m., survey staff toured the facility with the maintenance manager (MM)-E. During the facility tour, survey staff observed that a marked exit led to an outdoor space enclosed by a fence. A padlock was installed on the fence gate. All paths	{0 820}			

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{0 820}	Continued From page 16 of egress must be maintained and clear of obstructions to allow residents, staff, and visitors to exit the building in a safe and efficient manner in the event of an emergency. This deficient condition was visually verified by MM-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	{0 820}			
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Not assessed	{0 930}			

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{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}			

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{0 940}	Continued From page 18 Not assessed	{0 940}			
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not assessed	{01530}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}			

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{01620}	Continued From page 19 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure documentation of incidents involving the resident and actions taken in response to the needs of the resident were completed for one of nine residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	{01620}			

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{01620}	Continued From page 20 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4's diagnoses included dementia, glaucoma, and macular degeneration. R4's care plan dated March 24, 2023, indicated R4 was independent with ambulation with use of a walker. R4's Individual Abuse Prevention Plan (IAPP), dated March 24, 2023, indicated R4 had vision impairments, made poor decisions, was at risk for elopement, and had frequent safety checks. The document further indicated R4 felt he should be able to leave the facility on his own, made statements of not wanting to be at the facility, but had never attempted to leave the facility or property. R4's progress note, dated March 14, 2023, at 10:35 a.m. indicated R4 had been found in his room smoking a cigarette the evening prior. R4's smoking items were removed from his room, would be kept with staff, and provided to R4 when he is outside the facility. Staff will also assist R4 with lighting his cigarette. R4's progress note, dated March 15, 2023, at 2:17 p.m. indicated R4 had been more confused for the past four days. The note indicated R4 had been smoking in the facility, burning holes in his clothing while smoking, wandering into other resident's rooms during the night waking them from sleep and accusing them of taking his belongings. R4's progress note, dated March 16, 2023, at 4:00 p.m., indicated R4 had been going outside into the parking lot wandering, trying to get to the	{01620}			

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{01620}	Continued From page 21 store. The note indicated it was clear R4 did not know how to get to the store. R4's progress note, dated March 16, 2023, at 5:12 p.m., indicated administration staff had a discussion with R4's family regarding a change in behaviors and the possibility of R4 needing to move to a secured facility. R4's progress note, dated March 16, 2023, at 5:37 p.m., indicated R4 had wandered into other residents' rooms, was unhappy he could not have his cigarettes, and wanted to go to the store on two separate occasions, once for cigarettes and once for juice. Staff members redirected him. R4's progress notes, dated between March 24, and April 5, 2023, included five entries indicating family and licensee administration were working on relocating R4 to a secured facility. R4's treatment assistance record (TAR), dated April 2023, indicated R4 was on hourly safety checks. During observation on April 18, 2023, at 1:15 p.m., an unidentified staff (US) entered the registered nurses (RN)-A, also the director of nursing, office and informed her of an incident which had just occurred. The surveyor heard the US state they have him back in the building now. The surveyor went to the front lobby area and observed three staff standing around R4 while he sat in a chair near the front entrance. As the surveyor approached the area, R4 exited to the patio area to have a cigarette and staff left the area During an interview on April 18, 2023, at 1:25 p.m., when the surveyor asked the unlicensed	{01620}			

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{01620}	Continued From page 22 personnel (ULP)-B if she knew of a resident leaving the building a short time ago, ULP-B stated she was sitting outside when she noticed R4 had exited the facility and was walking in the parking lot. ULP-B stated she redirected R4 back into the facility. ULP-B also stated approximately four weeks ago, on a Saturday she was off work, she saw R4 at the gas station next door to the facility and brought him back to the facility. ULP-B stated she called RN-A to notify her of the incident. ULP-B further stated R4 goes out of the facility at least one time per week. ULP-B stated if she is the staff who redirects R4 back into the facility, she documents in R4's behavior notes or sends a message to RN-A or administration through the electronic medical record (EMR). Further review of R4's record did not identify assessments completed for R4's April 18, 2023, incident or any other incidents stated during the interview with ULP-B. During interview on May 18, 2023, at 1:00 p.m., RN-A initially stated she recalled the incident when ULP-B was not working but found R4 at the gas station and brought him back to the facility one Saturday. RN-A then thought she had the incident mixed up with a different incident involving R4. However, later in the interview, RN-A stated it was very possible that specific Saturday incident occurred. RN-A stated R4 was exiting out the front doors but it was hard to know how often he was doing it. RN-A stated there were no incident reports in R4's record, but there should have been. The licensee's 2.25 Incident Report policy dated January 1, 2023, indicated any incident involving a resident must be reported to management and an incident report form should be completed to	{01620}			

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{01620}	Continued From page 23	{01620}			
{01940} SS=D	document what happened. The policy indicated all incident reports related to residents will be kept in their records. 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	{01940}			

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{01940}	Continued From page 24	{01940}			
	by: Not assessed				
{03000} SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	{03000}			

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{03000}	Continued From page 25 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of nine residents (R4, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 R4's diagnoses included dementia, glaucoma, and macular degeneration. R4's care plan dated March 24, 2023, indicated R4 was independent with ambulation with use of a walker. R4's	{03000}			

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{03000}	Continued From page 26 Individual Abuse Prevention Plan (IAPP), dated March 24, 2023, indicated R4 had vision impairments, made poor decisions, was at risk for elopement, and had frequent safety checks. The document further indicated R4 felt he should be able to leave the facility on his own, made statements of not wanting to be at the facility, but had never attempted to leave the facility or property. R4's treatment assistance record (TAR), dated April 2023, indicated R4 was on hourly safety checks. During observation on April 18, 2023, at 1:15 p.m., an unidentified staff (US) entered the registered nurses (RN)-A, also the director of nursing, office and informed her of an incident which had just occurred. The surveyor heard the US state they have him back in the building now. The surveyor went to the front lobby area and observed three staff standing around R4 while he sat in a chair near the front entrance. As the surveyor approached the area, R4 exited to the patio area to have a cigarette and staff left the area. During an interview on April 18, 2023, at 1:25 p.m., when the surveyor asked the unlicensed personnel (ULP)-B if she knew of a resident leaving the building a short time ago, ULP-B stated she was sitting outside when she noticed R4 had exited the facility and was walking in the parking lot. ULP-B stated she redirected R4 back into the facility. ULP-B also stated approximately four weeks ago, on a Saturday she was off work, she saw R4 at the gas station next door to the facility and brought him back to the facility. ULP-B stated she called RN-A to notify her of the incident. ULP-B further stated R4 goes out of the	{03000}			

Minnesota Department of Health

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{03000}	Continued From page 27 facility at least one time per week. ULP-B stated if she is the staff who redirects R4 back into the facility, she documents in R4's behavior notes or sends a message to RN-A or administration through the electronic medical record (EMR). Further review of R4's record did not identify any incident reports were completed for R4's April 18, 2023 incident or any other incidents stated during the interview with ULP-B. R7 R7's diagnoses included Alzheimer's. R7's care plan, dated April 4, 2023, indicated R7 was independent with ambulation with use of a walker, required assistance with transfers and medication management. The document further indicated R7 had had severe impairment with memory problems and was at risk for falls. R7 had a call pendant and had safety check monitoring in place. An incident report dated March 18, 2023, at 1:00 p.m., indicated R7 fell in her bedroom, hit her head, hurt her right hand, had blood on her legs, hands, and face, and sustained a suspected fracture. The report indicated a kitchen chair was tipped on its side, approximately three feet from R7. The report also indicated the ambulance was called and R7 was transported to the emergency room for suspected fracture and facial injuries indicating she had hit her head. The Minnesota Adult Abuse Reporting Center (MAARC) report indicated the report was completed on March 29, 2023, at 12:26 p.m. The licensee 11.15 Falls Prevention and Reduction policy, dated March 1, 2023, indicated	{03000}			

Minnesota Department of Health

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{03000}	Continued From page 28 a witnessed or un-witnessed fall, with suspicion of hitting their head, 911 should be summoned unless licensed personnel were in the building to complete a neurological exam to deem the resident to be okay. The policy indicated the registered nurse would follow up and investigate each fall and determine if it were reportable. The policy further indicated all falls with significant injuries must be reported to the Minnesota Adult Abuse Reporting Center (MAARC). The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2023, indicated the licensee educate staff how to report suspected maltreatment internally and to the MAARC. Staff who suspect maltreatment of a resident or who has knowledge of abuse, financial exploitation, neglect, or a resident who has sustained a physical injury which is not reasonably explained, are to take immediate action to protect, or keep safe, the resident affected. The policy indicated such report must be made no later than 24 hours after first suspected.	{03000}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE EXTENSION AND SURVEY RESULTS

Electronically Delivered

February 28, 2023

Licensee
Rivers Edge Assisted Living
11 Minnesota Avenue
South Aitkin, MN 56431

RE: Conditional License Number 408222
Health Facility Identification Number (HFID) 32649
Project Number SL32649015

Dear Licensee:

On January 24, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on April 13, 2022, and during the follow up evaluation completed October 5, 2022. This follow-up evaluation determined your facility found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, the current Conditional License will be extended by an additional 75 days. This extension is due to expire on **May 14, 2023**.

With the exception of the revisions noted below, all conditions noted in the Conditional Order effective on July 19, 2022, will remain in effect through the extended conditional license period.

The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Rivers Edge Assisted Living and the RN consultant about a change. Each report will be electronically submitted to Paul Spencer, State Evaluation Team, Health Regulation Division, at paul.spencer@state.mn.us. Paul Spencer can be reached at 651-587-4460 with questions about the report.

Revised Conditions:

Therefore, effective on the date of this letter, the condition headed "**h. Assisted Living Facility with Dementia Care License**", imposed on October 14, 2022, is revised.

Rivers Edge must engage a neutral third party RN to conduct assessments of the current residents per the requirements of Minn. Rule 4659.0140 to determine which residents need services requiring an assisted living facility with dementia care license. MDH must approve the RN prior to the assessments. Rivers Edge will then work with MDH to comply with the requirements of Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55 for providing notice to residents requiring those services, and to transfer them to a facility licensed for assisted living with dementia care in a safe and timely manner.

Licensing Orders:

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), at the time of this follow-up evaluation completed on January 24, 2023, we identified the following violation(s):

0450-Minimum Requirements-144g.41 Subdivision 1 - \$3,000.00

0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (a)

0730-Contents Of Resident Record-144g.43 Subd. 3

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - \$3,000.00

3000-Timing Of Report-626.557 Subd. 3

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN
55164-9070

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer at 651-587-4460.

Please note, 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.

Sincerely,



Lindsey Krueger, RN
Assistant Division Director

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

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{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: #SL32649015 On January 23 through January 24, 2023, the Minnesota Department of Health conducted licensing order follow-up at the above provider and the following correction orders are issued or reissued. At the time of the survey, there were 33 residents receiving services. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date. The following immediate correction order was issued for #SL32649015: tag identification 1620. The following correction orders include additional orders are issued or reissued that were not issued at the time of the immediate correction orders. Please see the proceeding form.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not assessed	{0 115}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation;	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 2 (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 3	{0 250}			
0 450 SS=G	Not assessed 144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide person-centered care in compliance with the Nurse Practice Act when the license failed to identify or implement interventions to prevent future falls for two of nine residents (R1 and R4) records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 450			

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0 450	Continued From page 4 The Nurse Practice Act indicated the nurse must develop nursing interventions to be integrated with the plan of care and delegate nursing tasks to implement the plan of care. The American Journal of Nursing article titled "When a Fall Occurs" dated November 2007, volume 107, number 11, indicated fall analysis should be completed to identify the underlying causes and risk factors of the fall. The article further indicated immediate follow-up would help identify and enable staff to initiate preventative measures. R1 R1 admitted to the facility November 5, 2021. R1's diagnosis included Parkinson's disease. R1's care plan, dated January 2, 2023, indicated R1 was at risk for falls, required staff assist with ambulation, and required the use of a gait belt and a walker when ambulating. The care plan also indicated R1 had impaired judgement, forgetful, and disoriented to time and place. R1's assessment dated January 2, 2023, directed caregivers to remind R1 to use a walker and use a wheelchair R1 had difficulty ambulating. R1's incident report dated November 17, 2022, at 10:30 a.m., indicated R1 was found on the bathroom floor and obtain an abrasion on his back. The same document indicated R1 attempted to use the toilet paper holder as a safety bar as it was observed broken off from the wall. The same document indicated the resident did not use the call system appropriately. The	0 450			

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0 450	Continued From page 5 same document indicated actions taken to prevent future falls have the call pendant within reach at all times. R1's incident report dated December 2, 2022, at 10:15 a.m., indicated R1 lost his balance and fell while walking. The same document indicated R1 did not use his pendant because he was not wearing it. The same document indicated R1 was not wearing his pendant. The record indicated actions taken to prevent future falls were to assess the need for transfer and ambulation assistance. R1's incident report dated December 9, 2022, at 5:00 a.m., indicated R1 was found on the bedroom floor and sustained a laceration to his left ear and a suspected head injury. The same document indicated the resident did not use the call system appropriately. The record indicated actions taken to prevent future falls were to provide the resident with a front wheeled walker for ambulation. The same document indicated R1 was transported to hospital. The same document indicated the resident did not use the call system appropriately. R1's incident report dated December 9, 2022, at 11:45 a.m., indicated R1 was found on the bathroom floor and sustained a cut to his head. The same document indicated R1 was ambulating himself from the bed to the bathroom and was laying in a "puddle" of blood. The same document indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. 911 was called. R1's hospital record dated December 10, 2022 at	0 450			

Minnesota Department of Health

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0 450	Continued From page 6 1:50 a.m., indicated R1 had been to the emergency room for a recent earlier fall which resulted in an ear laceration. The same document indicated R1 required staples in his head due to a head laceration. R1 knew his self but varied on whether he knew place. R1's hospital discharge orders dated December 12, 2022, at 10:30 a.m., indicated R1 required a fall risk assessment and implementation of falls precautions as needed. The same document included the diagnosis Parkinson's disease with dementia was hospitalized for a subarachnoid bleed. R1's progress notes dated December 11, 2022, at 1:04 p.m., indicated the resident was "resistant and aggressive" toward staff members upon returning to the facility including hitting, kicking, twisting arms, and squeezing. R1's incident report dated December 13, 2022, at 10:00 p.m., indicated R1 fell out of bed. The same document indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. R1's incident report dated December 17, 2022, at 4:25 a.m., indicated R1 rolled out of bed and was found on the floor and obtained a bump on the left side of his forehead with a small cut. The same document indicated the resident did not use the call system appropriately. The record indicated actions taken to prevent future falls were to provide assistance with toileting. R1's incident report dated December 18, 2022, at 4:00 p.m., indicated R1 fell from a wheelchair while attempting to stand up. The same	0 450			

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0 450	Continued From page 7 document indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. R1's assessment dated January 2, 2023, indicated R1 could transfer without help, required standby assistance when ambulating with walker and to use wheelchair for R1 "when weak". The same document indicated to provide transfer assistance with toileting as requested by R1 and R1 had a call pendant and understood the use of it. The same document indicated actions taken to address fall risk included use of a call pendant to ask for assistance, reminders to use a walker, staff member assistance with ambulation, and use of a wheelchair if R1 had difficulty ambulating. R1 exhibited no behavior indicative of elopement risk due to no history of elopement but required escort outside the facility. R1's incident report dated January 12, 2023, at 9:15 a.m., indicated R1 was found on the floor in his bedroom doorway on top of his walker and sustained a skin tear or laceration and a bruise. The same document indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. R1's progress notes dated January 12, 2022, at 12:50 p.m., indicated R1 may caught the edge of a couch when he fell earlier in the day and the licensee re-arranged R1's furniture to create a wider walkway. R1's incident report dated January 19, 2023, at 1:00 p.m., indicated R1 fell while ambulating in his room and hit his head. The same document indicated his walker was within reach and the	0 450			

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0 450	Continued From page 8 resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. R1's progress noted dated January 19, at 1:55 p.m., indicated the resident had gone outside of the building the day before in shorts and a T-shirt stating he was trying to get home. R1's incident report dated January 21, 2023, at 2:30 a.m., indicated R1 was found on the bathroom floor and sustained a skin tear or laceration. The same document indicated R1 was heard calling for help and was found in the bathroom attempting to use the toilet. The same document indicated the resident did not use the call system appropriately. A review of the document indicated the area labeled "actions taken to prevent future falls" was blank. R1's medical record included a note dated January 21, 2023, at 9:30 p.m., which was labeled 911 Call indicated a worker at a gas station reported R1 fell, ambulance and police responded, and the resident was taken to the hospital. R1's progress note dated January 22, 2023, at 9:29 a.m., indicated R1 sustained a cut on his head the night before when he fell coming out of the gas station next door and went to the emergency room. The same document indicated R1 admitted to the hospital. R4 R4 admitted to the facility June 5, 2022. R4's	0 450			

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0 450	Continued From page 9 diagnosis included pancreatic cancer. R4's assessment, dated December 17, 2022, indicated R4 was at risk for falls, required staff assist with transfers and toileting, and used a wheelchair for mobility. R4's record included the following incident reports on: R4's incident report dated December 13, 2022, at 9:00 a.m., indicated R4 fell while ambulating in the resident living area and obtained a scrape to her right arm/shoulder, right leg, and left knee. A review of the document did not identify interventions to prevent future falls. R4's incident report dated December 13, 2022, at 4:40 p.m., indicated R4 fell while ambulating in the resident living area. A review of the document did not identify interventions to prevent future falls. R4's incident report dated December 14, 2022, at 6:00 p.m., indicated R4 rolled off the couch. A review of the document did not identify interventions to prevent future falls. During an interview on January 24, 2023, at 12:10 p.m., the director of nursing (DON)-A, stated the section on the incident report labeled actions taken to prevent future falls is the same as an intervention. DON-A stated if an intervention were put in place following a fall, the surveyor would find it on the incident report under the actions taken to prevent future falls section. The licensee falls policy was requested, but not provided.	0 450			

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0 450	Continued From page 10	0 450			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
{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: Not assessed	{0 480}			
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of nine resident (R1) with records reviewed. 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	0 620			

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0 620	Continued From page 11 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 5, 2021. R1's diagnosis included Parkinson's disease. R1's care plan, dated January 1, 2023, indicated R1 was at risk for falls, required staff assist with ambulation, and required the use of a gait belt and a walker when ambulating. The care plan also indicated R1 had impaired judgement, was forgetful, and disoriented to time and place. An incident report dated December 9, 2022, at 11:45 a.m., indicated R1 was found on the bathroom floor laying in a puddle of blood with a cut to his head. The report indicated R1 was sent to the emergency room (ER) for evaluation. A hospital Admission History and Physical indicated R1 admitted to the emergency room (ER) on December 10, 2022, at 12:14 a.m. The report indicated R1's chief complaints included a traumatic subarachnoid hemorrhage with unknown loss of consciousness status, contusion of buttock, laceration of left ear, and laceration of occipital region of scalp. The report indicated R1 was in the ER 24 hours prior to this incident from another fall and had obtained multiple injuries from both falls. An incident report dated January 21, 2023, at 9:30 p.m., indicated R1 fell outside at the gas station next door to the facility and obtained a laceration to his head. A progress note dated January 22, 2023, at 9:29	0 620		

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0 620	Continued From page 12 a.m., indicated R1 was taken to the ER for a cut on his head and was admitted to the hospital. During an interview on January 23, 2023, at 11:50 a.m. R1's family member (FM)-G stated R1 received 5 stitches for a cut to his head and had a brain bleed, both injuries were related to the January 21, 2023, fall. FM-G stated R1 had a brain bleed from a fall in his shower within the last six months also. During an interview on January 23, 2023, at 9:00 a.m., the director of nursing (DON)-A, stated she did not call the Minnesota Adult Abuse Reporting Center (MAARC) to file a report for R1's incident because she thought the hospital would do that. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2023, identified the facility educated staff about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). Upon hire and annually all staff will be trained on identifying and reporting suspected maltreatment of vulnerable adults. Staff who suspect maltreatment of a resident or who has knowledge of abuse are to take immediate action to protect, or keep safe, the resident affected. Staff are to call 911 if emergency assistance is needed and contact the clinical nurse supervisor if medical attention needed and/or contact the assisted living director. The assisted living director or clinical nurse will confirm suspicion of maltreatment and contact the MAARC, such report must be made no later than 24 hours after first suspected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			

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{0 630}	Continued From page 13	{0 630}			
{0 630} SS=F	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: Not assessed	{0 630}			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 14 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure documentation of incidents involving the resident and actions taken in response to the needs of the resident were completed for one of nine residents (R1) with records reviewed. This practice resulted in a level two violation (a	0 730			

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0 730	Continued From page 15 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: R1 was admitted on November 5, 2021. R1's diagnosis included Parkinson's disease. R1's care plan, dated January 1, 2023, indicated R1 was at risk for falls, required staff assist with ambulation, and required the use of a gait belt and a walker when ambulating. The care plan also indicated R1 had impaired judgement, was forgetful, and disoriented to time and place. During an interview, which was conducted during an onsite visit between January 23 through January 24, 2023, employee #1 stated there were residents who had exited the facility alone that should not have and should be in a secured unit, or at minimum have had more supervision than the facility can provide. Employee #1 stated the licensee hired someone to be at the main desk during the day to provide extra supervision; however, the employee drives residents to and from appointments throughout the day and is not always available. Employee #1 stated there are undocumented incidents of residents exiting the facility because staff are unsure what or how to document an incident according to managements recommendations. Employee #1 stated management has made comments to staff regarding their documentation, such as why did you document that, or why did you document it that way.	0 730			

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0 730	Continued From page 16 During an interview, which was conducted during an onsite visit between January 23 through January 24, 2023, employee #2 stated she was not aware of any charting requirements for exit seeking or exiting the building. Employee #2 stated she had witnessed residents going out of the building alone who should not have but did not document the incident in the resident record. Employee #2 stated R1 had exited the building two times during her shift. Employee #2 stated she was unsure of the date the first incident occurred, but it was sometime after Christmas when R1 went out the main door to throw garbage away. Employee #2 stated the second incident occurred on January 20, 2023, when R1 went out to the patio in a t-shirt, sweatpants, and tennis shoes. Employee 2 denied charting on either incident, but stated she told the director of nursing (DON)-A about the January 20, 2023, incident. During an interview, which was conducted during an onsite visit between January 23 through January 24, 2023, employee #3 stated there are residents here that belong in secured unit. Employee #3 stated she feels like staff cannot document like they should because management makes a "big deal out of things". Employee #3 stated management staff have made comments such as you should not have charted that, and we get lectured to not use the word "wander". Employee #3 stated R1 was exit-seeking and had multiple incidents the previous week during which he was outside or trying to go outside. Employee #3 stated on January 18, 2023, or the following day, R1 had another incident in addition to the two incidents already documented. Employee #3 further stated R1 was out on the patio on January 20, 2023, around 5:00 p.m. in a t-shirt,	0 730			

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0 730	Continued From page 17 sweatpants, and socks, carrying a blanket, and talking to someone. Employee #3 stated she was unsure how long R1 was outside during that incident, but he was shaking (shivering) badly. R1's record included the following incident reports on: -January 18, 2023, at 4:00 p.m. indicated R1 had to be brought back into the building two times. -January 21, 2023, at 9:30 p.m. indicated R1 eloped from the facility and was at the gas station next door. Further review of R1's record did not identify an incident occurred on January 19, 2023, January 20, 2023, or an additional incident on January 18, 2023, as stated in the interviews. The licensee's Incident Report policy dated January 1, 2023, indicated any incident to a resident, visitor, staff, or to the property or grounds needs to be reported to Rivers Edge Assisted Living, Inc management and an incident report form should be completed to document what happened. The policy further indicated all incident reports related to residents would be kept in the resident records. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	{0 780}			

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{0 780}	Continued From page 18 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Not assessed	{0 780}			
{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	{0 810}			

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{0 810}	Continued From page 19 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Not assessed	{0 810}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	{0 820}		

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{0 820}	Continued From page 20 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Not assessed	{0 820}			
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Not assessed	{0 930}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/24/2023
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
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{0 940}	Continued From page 21	{0 940}			
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	{0 940}			

Minnesota Department of Health

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{0 940}	Continued From page 22 This MN Requirement is not met as evidenced by: Not assessed	{0 940}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Not assessed	{01530}		

Minnesota Department of Health

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01620	Continued From page 23	01620			
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to reassess and monitor change in needs when the resident exhibited exit-seeking behaviors while not wearing clothing appropriate for the weather. Additionally, the resident left the facility unsupervised, fell, and required hospitalization. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01620			

Minnesota Department of Health

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01620	Continued From page 24 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Parkinson's. R1's care plan dated January 2, 2023, indicated R1 required supervision to walk with use of a front wheeled walker and needed escorts when outside of the facility. The same document indicated R1 had impaired memory and was at risk for falls. An incident report dated January 18, 2023 at 4:00 p.m., indicated R1 was brought in from outside by a staff member on two occasions. The same document indicated R1 was not dressed appropriately for the weather outside as he was wearing a T-shirt, shorts, and slippers. The same document indicated on one occasion R1 was in a fenced area trying to open the gate and said he was trying to get out to go home. R1's progress notes dated January 19, 2023, at 2:44 p.m. indicated R1 required being brought back into the building by staff members on the previous day, January 18, 2023. The same document indicated one occasion involved the "foyer" and another at the fenced patio area. An incident report dated January 21, 2023, at 9:30 p.m., indicated a worker at the gas station next to the facility called 911 because R1 fell. The report indicated the ambulance and police officer arrived on scene and R1 was transferred	01620			

Minnesota Department of Health

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01620	Continued From page 25 to the hospital. R1's progress note, dated January 22, 2023, at 9:29 a.m., indicated law enforcement (LE) stopped at the facility the prior evening to notify them R1 had fallen at the gas station next door. The same document indicated the LE said R1 cut his head and was transferred to the hospital by the ambulance. During an interview on January 23, 2023, at 9:00 a.m., RN-A stated R1 left the facility on January 21, 2023, walked over to the gas station next door, and fell over there. RN-A stated a gas station worker came to the facility and informed facility staff of the incident; LE also stopped over later to inform staff. RN-A stated R1 lives in an apartment on the first floor, did not sustain any fractures, and was hospitalized. TIME PERIOD FOR CORRECTION: Immediate	01620		
{01940} SS=D	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	{01940}		

Minnesota Department of Health

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{01940}	Continued From page 26 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: Not assessed	{01940}			
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the	03000			

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03000	Continued From page 27 previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of nine	03000			

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03000	Continued From page 28 residents (R1) with records reviewed. 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: R1 was admitted on November 5, 2021. R1's diagnosis included Parkinson's disease. R1's care plan, dated January 1, 2023, indicated R1 was at risk for falls, required staff assist with ambulation, and required the use of a gait belt and a walker when ambulating. The care plan also indicated R1 had impaired judgement, was forgetful, and disoriented to time and place. An incident report dated December 9, 2022, at 11:45 a.m., indicated R1 was found on the bathroom floor laying in a puddle of blood with a cut to his head. The report indicated R1 was sent to the emergency room (ER) for evaluation. A hospital Admission History and Physical indicated R1 admitted to the emergency room (ER) on December 10, 2022, at 12:14 a.m. The report indicated R1's chief complaints included a traumatic subarachnoid hemorrhage with unknown loss of consciousness status, contusion of buttock, laceration of left ear, and laceration of occipital region of scalp. The report indicated R1 was in the ER 24 hours prior to this incident from another fall and had obtained multiple injuries from both falls.	03000			

Minnesota Department of Health

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03000	Continued From page 29 An incident report dated January 21, 2023, at 9:30 p.m., indicated R1 fell outside at the gas station next door to the facility and obtained a laceration to his head. A progress note dated January 22, 2023, at 9:29 a.m., indicated R1 was taken to the ER for a cut on his head and was admitted to the hospital. During an interview on January 23, 2023, at 11:50 a.m. R1's family member (FM)-G stated R1 received 5 stitches for a cut to his head and had a brain bleed, both injuries were related to the January 21, 2023, fall. FM-G stated R1 had a brain bleed from a fall in his shower within the last six months also. During an interview on January 23, 2023, at 9:00 a.m., the director of nursing (DON)-A, stated she did not call the Minnesota Adult Abuse Reporting Center (MAARC) to file a report for R1's incident because she thought the hospital would do that. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated January 1, 2023, identified the facility educated staff about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). Upon hire and annually all staff will be trained on identifying and reporting suspected maltreatment of vulnerable adults. Staff who suspect maltreatment of a resident or who has knowledge of abuse are to take immediate action to protect, or keep safe, the resident affected. Staff are to call 911 if emergency assistance is needed and contact the clinical nurse supervisor if medical attention needed and/or contact the assisted living director. The assisted living director or clinical nurse will	03000			

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03000	Continued From page 30 confirm suspicion of maltreatment and contact the MAARC, such report must be made no later than 24 hours after first suspected. TIME PERIOD FOR CORRECTION: Seven (7) days	03000			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE EXTENSION AND SURVEY RESULTS

Electronically Delivered

October 14, 2022

Administrator
Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431

RE: Conditional License Number 408222
Health Facility Identification Number (HFID) 32649
Project Number SL32649015

Dear Administrator:

On October 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on April 13, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the April 13, 2022 evaluation.

As a result, the current Conditional License will be extended by an additional 60 days. This extension is due to expire on **December 16, 2022**.

With the exception of the revisions noted below, all conditions noted in the Conditional Order effective on July 19, 2022, will remain in effect through the extended conditional license period.

The RN consultant will continue to provide MDH with regular reports at intervals specified by MDH. Reports will continue on a weekly basis until MDH notifies Rivers Edge Assisted Living and the RN consultant about a change. Each report will be electronically submitted to Paul Spencer, State Evaluation Team, Health Regulation Division, at paul.spencer@state.mn.us. Paul Spencer can be reached at 651-587-4460 with questions about the report.

Revised Conditions:

The condition headed "**b. No new admissions**" is revised. The portion of this condition restricting new admissions of residents not in need of services requiring an assisted living facility with dementia care license is lifted as of the date of this letter, and such residents may be admitted to the facility per the requirements of Minn. Stat. Chpt. 144G.

Rivers Edge Assisted Living may not admit any new residents who are in need of services requiring an assisted living facility with dementia care license. This applies for the duration of the assisted living facility license under HFID 32649 per the definitions of assisted living facility license and assisted living facility with dementia care found in Minn. Stat. § 144G.08 Subds. 7a and 8, as the facility is not licensed as an assisted living facility with dementia care.

The conditions headed "**h. Assisted Living Facility with Dementia Care License**" and "**i. Physical Environment**"

Requirements" are also revised. These conditions required Rivers Edge to work with MDH to come into compliance with the requirements for assisted living facility with dementia care licensure under Minn. Stat. §144G.08, Subd. 8, and Minn. Stat. § 144G.81. MDH acknowledges that Rivers Edge made a good faith effort to comply with these conditions; however, after review of the provisional assisted living with dementia care license application, waiver request, building information, and an informal conference with Rivers Edge representatives on October 11, 2022, Rivers Edge determined, and MDH acknowledged that the facility would not be able to meet the requirements for assisted living with dementia care licensure. With this understanding, Rivers Edge indicated that they would like to withdraw the provisional assisted living license application and continue operating as an assisted living facility licensee.

Therefore, effective on the date of this letter, conditions **h** and **i**, imposed on July 19, 2022, are rescinded. These conditions are replaced with the following:

Rivers Edge will conduct assessments of the current memory care residents per the requirements of Minn. Rule 4659.0140 to determine which residents need services requiring an assisted living facility with dementia care license. Rivers Edge will then work with MDH to comply with the requirements of Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55 for providing notice to residents requiring those services, and to transfer them to a facility licensed for assisted living with dementia care in a safe and timely manner.

For the safety of the current memory care residents, Rivers Edge must maintain the locking for the secured unit during the transfer process. The locking must be removed when transfer of the memory care residents is complete.

Licensing Orders:

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on April 13, 2022, found not corrected at the time of the October 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1- \$500.00

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - \$500.00

0580-Quality Management-144g.42 Subd. 2 - \$500.00

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b) - \$500.00

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3

The details of the violations noted at the time of this follow-up evaluation completed on October 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on October 5, 2022, we identified the following violation(s):

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

1530-Training In Dementia Care Required-144g.64

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached

State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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.

Pursuant to Minn. Stat. §144G.20, Subd. 3 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the licensee receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order.

We urge you to review these orders carefully. If you have questions, please contact Paul Spencer at 651-587-4460.

Please note, 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.

Sincerely,

A handwritten signature in black ink that reads "Maria King". The signature is written in a cursive, flowing style.

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/05/2022
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(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. ----- ----- ----- On October 4, 2022, the Minnesota Department of Health initiated a licensing order follow-up for survey SL32649015 and issued the following correction order prior to the end of the onsite visit: 630. There may be further correction orders issued at a later date. ----- ----- ----- INITIAL COMMENTS: SL#SL32649015 On October 3, 2022 through October 5, 2022-, the Minnesota Department of Health conducted	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to		

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

TITLE

(X6) DATE

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{0 000}	Continued From page 1 licensing order follow-up at the above provider and the following correction orders are issued or reissued (see proceeding form). At the time of the survey, there were 35 residents, all of whom received services; XX receiving services under the provider's Assisted Living license.	{0 000}	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.	
{0 115} SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care	{0 115}		

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{0 115}	Continued From page 2 category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not assessed.	{0 115}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	{0 250}		

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{0 250}	Continued From page 3 files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	{0 250}			

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{0 250}	Continued From page 4 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 plan of correction visit on October 3, 2022, at 9:00 a.m., Minnesota Department of Health (MDH) surveyors requested from the licensed assisted living director (LALD)-B and received the licensee's corrective actions documentation for correction orders issued. As a result of this plan of correction survey, the following orders were reissued or issued 0480, 0580, 0630, 0780, 0810, 820, 1530, and 1940 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	{0 250}			
{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: (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	{0 480}			

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{0 480}	Continued From page 5 fresh vegetables. The following apply: (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 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, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 4, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident	{0 580}			

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{0 580}	Continued From page 6 services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity in accordance with 144G.42 Subd.2. This had the potential to affect all 35 residents receiving assisted living services. 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 3, 2022, licensed assisted living director (LALD)-B provided a three-ring binder containing the licensee's corrective action plan for quality management improvement. Review of the licensee's quality management corrective action plan indicated licensee's quality management was currently working on "Core Values." The Core Values consisted of the acronym R.E.A.L. which represented R=respect,	{0 580}			

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{0 580}	Continued From page 7 E=empathy, A=accountability, and L=loyalty. Review of quality management audit dated August 16, 2022, identified discussion of the R=respect of residents from the Core Values and with progress in place. Document did not provide staff involved in discussion or what the discussion involved. Review of quality management audit dated September 7, 2022, identified the discussion of the confusion on who staff are to report regarding lines of communication. Document did not provide staff involved in discussion or what the discussion involved. During an interview with registered nurse (RN)-A on October 5, 2022, at 1:20 p.m., stated she was part of the quality management and identified the quality management was working on the CORE values. During an interview on October 5, 2022, at 2:15 p.m., LALD-B stated the quality management team included RN-A and LALD-B. LALD-B confirmed quality management was working on the Core Values which focused on not just staff. LALD-B stated verbal conversations regarding concerns from residents, falls, and other incidents discussed all the time but not documented, dated, signed who was involved in the verbal conversations, and no retention of records of such projects. The licensee-provided policy titled Quality Management Project dated August 1, 2021, indicated the licensee would always have at least one documented quality management project in place, and retain records of such projects for at least two years. "Quality management activity"	{0 580}			

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{0 580}	Continued From page 8	{0 580}			
{0 630} SS=F	means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determine whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. 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 observation, interview and record review, the licensee failed to ensure specific measures to reduce residents' risk of elopement 24 hours a day 7 days a week by providing some residents with the door code to unmonitored key code exit doors. This affected 17 of 35 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 630}			

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{0 630}	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: The resident roster dated October 3, 2022, indicated 17 of 35 residents identified as memory care residents. The list of residents who required staff supervision if leaving facility grounds dated October 3, 2022, identified 17 residents. On October 3, 2022, at 9:00 a.m., surveyors entered the facility. The facility door was only accessible by keycode. Upon entering, a common area observed. The common area included a staff desk, an elevator, a public bathroom, armchairs for resident seating, and television area with two couches, loveseat, and an armchair. In the same space was a key coded handicap door that led to the resident smoking area and patio. The common area housed a total of two key coded access doors. On October 3, 2022, at 9:50 a.m., no licensee staff observed at the common area desk. Two residents sat in the common area. On October 3, 2022, at 10:12 a.m., LALD-B stated the entire building used a key code system for entering and exiting. LALD-B stated both memory care residents and non-memory care residents lived together in the building. LALD-B stated the licensee added a new role which included a staff member assigned at the common area desk daily from 8:00 a.m. to 4:30 p.m. This staff member monitored common area doors and performed resident transport duties. LALD-B stated if that staff member had to leave to	{0 630}		

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{0 630}	Continued From page 10 transport a resident during shift, a different staff member covered monitoring the doors. LALD-B stated the licensee did not have staff monitoring the doors after 4:30 p.m. LALD-B stated it was possible a resident could allow another resident to leave who did not have the key code. On October 4, 2022, at 8:55 a.m., two residents were in the lobby, with no staff member present at the lobby desk monitoring the doors. At 9:10 a.m., unlicensed personnel (ULP)-F returned to the common area. On October 4, 2022, at 8:56 a.m., the surveyor took a picture of posted signage observed by the key coded patio/river handicap door. The posted signage read, "Stop Important Notice. For the safety of our residents, please do not allow anyone to exit the door when you pass through it." The same signage was posted at the other common area key coded door. On October 4, 2022, at 10:17 a.m., two residents observed in the common area, without licensee staff present monitoring the doors. At 10:30 a.m., a third resident entered the area. At 10:32 a.m., a fourth resident entered the area. At 10:33 a.m., ULP-F walked through the common area and went to the public bathroom. At 10:35 a.m., a fifth resident entered the area. At 10:35 a.m., ULP-F left the public bathroom, entered the elevator, and left the common area. At 10:55 a.m., four residents observed without staff present monitoring the doors. At 11:03 a.m., ULP-F returned and left out the front door. At 11:09 a.m., six residents observed in the common area without staff present monitoring the doors. At 11:19 a.m., seven residents observed in the common area without staff present monitoring the doors. At 11:20 a.m., ULP-F returned to the	{0 630}			

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{0 630}	Continued From page 11 common area. On October 4, 2022, at 11:30 a.m., ULP-F stated she was not assigned to cover the common area desk and the licensee did not have staff assigned today. On October 4, 2022, at 11:35 a.m., LALD-B stated the staff member assigned to common area desk for monitoring the doors was reassigned for the day to perform other duties. She stated ULP-F was supposed to assist with door monitoring today. She stated they do not assign coverage after 4:30 p.m., during the week and no staff scheduled to monitor doors on the weekends. When asked how the licensee was ensuring residents at risk for elopement are not exiting doors behind residents who have the key codes or behind family/visitors leaving the facility when there is no staff monitoring the doors, she stated staff performed extra safety checks on residents who have elopement risk.	{0 630}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	{0 780}			

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{0 780}	Continued From page 12 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 4, 2022, between 10:10 a.m. and 10:45 a.m., survey staff toured the facility with the maintenance manager (MM)-H. During the facility tour, survey staff observed that when a smoke alarm in resident apartment 218 was tested by MM-H, none of the other alarms within the dwelling unit were activated. During the tour interview, MM-H confirmed that these smoke alarms were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate.	{0 780}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 810}	Continued From page 13	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the	{0 810}		

Minnesota Department of Health

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{0 810}	Continued From page 14 licensee failed to provide the required evacuation drill frequency. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 4, 2022, at approximately 10:45 a.m., the licensed assisted living director (LALD)-B provided documents for review. Documents were reviewed by survey staff on October 4, 2022, between 10:45 a.m. and 11:30 a.m. The licensee failed to meet the twice per year per shift with at least one evacuation drill every other month frequency requirement. 1. The Fire and Fire Drill Policy dated August 1, 2021, included procedures for performing these evacuation drills but the frequency was not specified. 2. Documentation was requested for evacuation drills completed since the last survey. A fire and evacuation drill log was provided dated September 26, 2022. The time or shift of the drill was not recorded. No additional drill logs or schedules were provided for review. On October 4, 2022, at approximately 11:40 a.m., during the exit interview with the LALD-B, they confirmed that the shift had not been recorded for the fire and evacuation drill completed on September 26, 2022, and that the facility was still working on meeting the frequency requirements.	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 15 No further information was provided.	{0 810}			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 4, 2022, between 10:10 a.m. and 10:45 a.m., survey staff toured the facility with the maintenance manager (MM)-H. During the facility tour, survey staff observed that keypads were	0 820			

Minnesota Department of Health

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0 820	Continued From page 16 installed at three exit doors. A code entered into the keypad was required to open the exit doors. The facility was operating as a secured dementia care unit with an assisted living facility license. On October 4, 2022, at approximately 11:40 a.m., during the exit interview with the LALD-B, they confirmed that the exit doors required entry of a code into the keypad to open the door. The LALD-B explained that the independent residents had the codes and were trained on how to operate the keypads. They further explained that the dementia care residents had not been given the codes or received training on how to use these keypads. TIME PERIOD FOR CORRECTION: 120 (one-hundred twenty) days.	0 820			
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;	{0 930}			

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{0 930}	Continued From page 17 (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: No further action required.	{0 930}			
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for	{0 940}			

Minnesota Department of Health

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{0 940}	Continued From page 18 assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 940}		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	01530		

Minnesota Department of Health

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01530	Continued From page 19 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on, interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-G) received at least eight hours of dementia care training, in the required timeframe in accordance with 144G.64 with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's corrective action plan reviewed by evaluator on October 3, 2022, indicated the licensee would conduct audits to ensure dementia training was completed. ULP-G ULP-G's employee record indicated ULP-G completed 3.25 hours of dementia training, with a completion date of June 1, 2022. ULP-G's timecards for August and September	01530			

Minnesota Department of Health

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01530	Continued From page 20 2022, indicated ULP-G worked 273 hours. On October 5, 2022, at 1:25 p.m., registered nurse (RN)-A verified ULP-G did not receive the required hours of dementia training. The licensee-provided policy titled, Dementia Training, dated August 1, 2021, indicated direct care staff would complete eight hours of dementia initial training within 160 hours of the employment start date.	01530			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy management 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	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 21 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: Based on interview and record review, the licensee failed to develop an individualized treatment management plan with all required content for one of one resident (R2) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's corrective action plan reviewed by evaluator October 5, 2022, indicated R2 had an individualized treatment management plan R2 R2's start of care for services was November 11, 2021. R2's diagnoses included chronic Lyme's disease, high blood pressure, and dementia. R2's service plan indicated R2 required assistance with dressing, grooming, transfers, medication administration, and catheter care.	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 22 R2's service recap summary indicated ULPs completed catheter care from September 21, 2022, through October 3, 2022. R2's record did not include evidence the RN had developed an individualized treatment management plan with the required content for catheter cares including: -a statement of the type of services that will be provided - documentation of specific resident instructions relating to the treatment - identification of treatment or therapy tasks delegated to unlicensed personnel. - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 5, 2022, at 1:49 p.m., RN-A verified R2's individualized treatment and therapy plan did not identify R2's catheter care. The licensee-provided policy titled, Treatment and Therapy Management Plan, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident and should contain the following information: a statement of the service provided, documentation of specific instructions, identification of treatment or therapy tasks that will be delegated to ULPs, procedures for when to notify a nurse, resident specific requirements relating to documentation	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 23 of treatment or therapy, verification all treatment and therapy was administered as prescribed, and monitoring of the treatment or therapy to prevent possible complications.	{01940}			

Type: Follow-Up
Date: 10/04/22
Time: 10:45:03
Report: 6808221177

Food and Beverage Establishment Inspection Report

Page 1

Location:

Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN56431
Aitkin County, 01

Establishment Info:

ID #: 0038522
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184295785
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.

3-500A Microbial Control: cooling

3-501.14A **** Priority 1 ****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

MINESTRONE SOUP FROM 10/3 WAS STILL AT 50 DEGREES IN THE 2-DOOR COOLER.

Comply By: 10/04/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

DRINKS IN THE SMALL DOMESTIC TABLETOP COOLER WERE 44-45 DEGREES. DO NOT STORE TCS FOODS IN THIS UNIT.

Comply By: 10/04/22

3-700 Contaminated Food: discarded

3-701.11A **** Priority 1 ****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented. DISCARD THE MINESTRONE SOUP THAT HAD NOT COOLED PROPERLY.

Comply By: 10/04/22

Type: Follow-Up

Date: 10/04/22

Time: 10:45:03

Report: 6808221177

Rivers Edge Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

3-500A Microbial Control: cooling

3-501.15A

**** Priority 2 ****

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Comply By: 10/04/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REPLACE/REMOVE THE MAGIC CHEF TABLETOP COOLER.

Comply By: 11/05/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.110B

MN Rule 4626.1560B Use the lockers or other suitable facilities to store clothing and other possessions. DO NOT STORE COATS, PURSES AND OTHER PERSONAL BELONGINGS ON THE DRY STORAGE FOOD SHELVES.

Comply By: 10/04/22

Food and Equipment Temperatures

Process/Item: Cooling

Temperature: 50 Degrees Fahrenheit - Location: MINESTRONE SOUP DATED 10/3 WAS 50 DEGREES IN 2-DOOR UPRIGHT

Violation Issued: Yes

Process/Item: Upright Cooler

Temperature: 39-40 Degrees Fahrenheit - Location: CHICKEN ALFREDO, SPAGHETTI, VEG SOUP IN 2-DOOR

Violation Issued: No

Process/Item: Cold Holding

Temperature: 44-45 Degrees Fahrenheit - Location: MILK & ENSURE IN THE DOMESTIC TABLETOP UNIT

Violation Issued: Yes

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

THIS WAS A FOLLOW-UP INSPECTION. ALL PREVIOUS ORDERS FROM THE 4/11/22 INSPECTION HAVE BEEN COMPLIED WITH.

Type: Follow-Up

Date: 10/04/22

Time: 10:45:03

Report: 6808221177

Rivers Edge Assisted Living

Food and Beverage Establishment Inspection Report

Page 3

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 6808221177 of 10/04/22.

Certified Food Protection Manager Phillip Hollingsworth

Certification Number: _____ Expires: 02/14/24

Signed: _____

Establishment Representative

Signed: _____

Lee Ann Austin

Public Health Sanitarian

St. Cloud

320-223-7341

leeann.austin@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 19, 2022

Administrator
Rivers Edge Assisted Living
11 Minnesota Avenue South
Aitkin, MN 56431

RE: Conditional License Number 408222
Health Facility Identification Number (HFID) 32649
Project Number SL32649015

Dear Administrator:

The Minnesota Department of Health (MDH) completed an initial evaluation on April 13, 2022 for the purpose of assessing compliance with state licensing statutes and to determine issuance of an initial license to the above mentioned provider. Based on the initial evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on October 17, 2022.

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

St - 0 - 0620 - 144g.42 Subd. 6 (a) - Compliance With Requirements For Reporting - \$3,000.00

St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting - \$3,000.00

St - 0 - 1620 - 144g.70 Subd. 2 (c-e) - Initial Reviews, Assessments, And Monitoring - \$3,000.00

The total amount you are assessed is \$12,000.00. 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.

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

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**.

Conditional License Issued:

MDH will issue Rivers Edge Assisted Living a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Rivers Edge Assisted Living is in compliance.

The following conditions apply on the conditional assisted living facility license:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

- b. No new admissions:** Rivers Edge Assisted Living will not admit any new residents under its conditional assisted living facility license until the MDH removes the “no new admissions” condition. Rivers Edge Assisted Living must provide the Department:
 - i. A list of the names and birthdates of any individuals Rivers Edge Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

Consultant: Rivers Edge Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Rivers Edge Assisted Living provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Rivers Edge Assisted Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Rivers Edge Assisted Living and MDH must review the RN’s credentials and approve the selection. Rivers Edge Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Rivers Edge Assisted Living in an effort to help Rivers Edge Assisted Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Rivers Edge Assisted Living will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

- c. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Rivers Edge Assisted Living and the RN consultant about a change. Each report will be electronically submitted to Paul Spencer, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at paul.spencer@state.mn.us. Paul Spencer can be reached at 651-587-4460 (office) with questions about reports. The content of the reports will include information such as:

- i. Progress towards correction of licensing orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- d. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Rivers Edge Assisted Living to correct the violations cited during the evaluation as well as to determine the overall practice of Rivers Edge Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- e. **Follow-up Evaluation:** At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- f. **Corrective Action Plan:** Rivers Edge Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order
- h. **Assisted Living Facility with Dementia Care License:** River's Edge Assisted Living will work with MDH licensing to meet the requirements to obtain the Provisional ALFDC license that is required to serve its secure memory care unit population per Minn. Stat. §144G.08, Subd. 8.

- i. Physical Environment Requirements** River's Edge Assisted Living will work with MDH to come into compliance with Minn. Stat. § 144G.81 concerning the physical environment requirements for Assisted Living Facilities with secure dementia care units.

Results of Follow-Up Survey During the Conditional License Period:

MDH will determine if Rivers Edge Assisted Living is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Rivers Edge Assisted Living is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Rivers Edge Assisted Living's assisted living facility license, and Rivers Edge Assisted Living will correct violations identified during the evaluation to come into full compliance. If MDH determines Rivers Edge Assisted Living is not in substantial compliance, MDH may take additional enforcement action against Rivers Edge Assisted Living, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:

Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

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

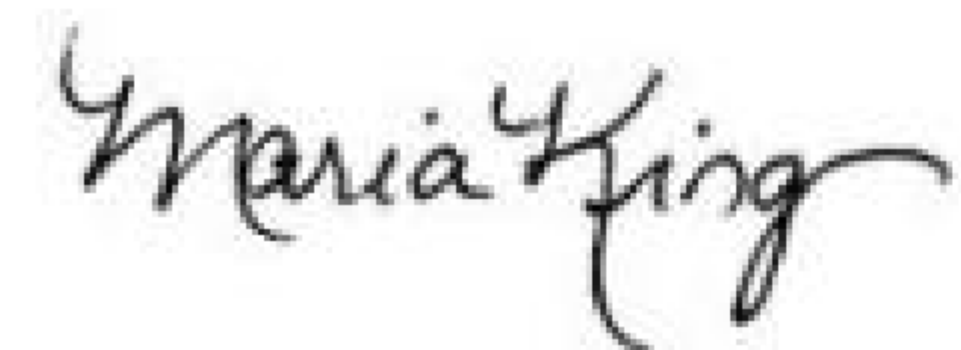
Rivers Edge Assisted Living

July 19, 2022

Page 6

If you have any questions, please contact Paul Spencer directly at: 651-587-4460.

Sincerely,

A handwritten signature in black ink that reads "Maria King". The signature is written in a cursive, flowing style.

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2022
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32649015 On April 11, 2022, through April 13, 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 37 residents receiving services under the provider's Assisted Living Facility license.	0 000	Assisted Living Provider 144G. 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. 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 115	Continued From page 1	0 115		
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure. (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure an assisted living facility with dementia care license was in place to meet compliance with the licensee's secured building serving memory care residents, only accessible by key codes. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee received an assisted living facility	0 115		

Minnesota Department of Health

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0 115	Continued From page 2 license effective August 1, 2021. The same license indicated a capacity of 45 beds. A review of the resident roster indicated the licensee identified 16 of 37 residents as memory care residents. On April 11, 2022, at 10:10 a.m., during an entrance conference, registered nurse (RN)-A stated both memory care residents and non-memory care residents lived together in the building. RN-A stated the entire building used a key code system for entering and exiting the building. RN-A stated all the exit doors of the facility had a key code. RN-A stated memory care residents did not live in a separate secured unit. RN-A stated the facility provided the key code to some residents used to come and go from the facility. RN-A and licensed assisted living director (LALD)-B both verified the licensee held an assisted living license. On April 11, 2022, at 12:55 p.m., a surveyor observed an unknown resident walking in from the side patio door, the door shut halfway, opened again, and stayed open approximately one minute when it shut on its own. During this observation, the surveyor saw no staff in the area. On April 11, 2022, at 1:55 p.m., RN-A stated the licensee did not have a system in place for ensuring a resident did not leave unsupervised that should not. RN-A verified a resident could leave through an open door, and it was possible a resident could allow another resident to leave who did not have the key code. RN-B verified the licensee did not have facility staff that monitored the doors nor any other systems in place to alert staff of residents coming and going from the facility.	0 115			

Minnesota Department of Health

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0 115	Continued From page 3 On April 11, 2022, at 2:50 p.m., LALD-B stated the licensee's new owner applied for an assisted living with dementia care license on their change of ownership application submitted to Minnesota Department of Health (MDH). On April 11, 2022, at 3:00 p.m., surveyors took a picture of patio/river handicap door. While outside surveyors spoke to R3 who stated he had the code to go outside to smoke. During the same observation an unidentified resident walked out the door followed by R5. The surveyors asked R5 if she had the code, and she did not respond. R3 stated R5 did not have a code, and someone must watch her, so she does not wander off. The surveyors observed R5 smoke on the patio with no staff members outside providing supervision with no barrier between the river and the patio. On April 11, 2022, at 3:06 p.m., ULP-C verified R5 should not be outside without staff present. On April 11, 2022, at 3:09 p.m., the surveyor took a picture of posted signage observed by the key coded patio/river handicap door. The posted signage read, "Stop Important Notice. For the safety of our residents, please do not allow anyone to exit the door when you pass through it." The same signage was posted at the other common area key coded door. A review of the licensee's change of ownership application indicated the assisted living license category applied for was an assisted living with dementia care and indicated a total licensed resident capacity of 66. The same application indicated there was not a secured dementia care unit at the facility.	0 115			

Minnesota Department of Health

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0 115	Continued From page 4 The licensee-provided policy titled Assisted Living License dated August 1, 2021, indicated the licensee would maintain a current assisted living license issued by the Minnesota Department of Health. TIME PERIOD FOR CORRECTION: Two (2) days.	0 115		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250		

Minnesota Department of Health

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0 250	Continued From page 5 access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 250		

Minnesota Department of Health

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0 250	Continued From page 6 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 11, 2022, at 10:10 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Inn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Inn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Inn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota	0 250		

Minnesota Department of Health

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0 250	Continued From page 7 Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Inn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Inn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Inn. Stat. chapter 144G,	0 250			

Minnesota Department of Health

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0 250	Continued From page 8 and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Inn. Stat. chapter 144G and Inn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page seventeen was signed by owner (OW)-G on July 15, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - medication and treatment management; and - supervision of unlicensed personnel performing	0 250			

Minnesota Department of Health

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0 250	Continued From page 9 delegated tasks. As a result of this survey, the following orders were issued 0115, 0430, 0470, 0480, 0490, 0530, 0540, 0550, 0580, 0620, 0630, 0650, 0780, 0810, 0930, 0940, 1330, 1420, 1470, 1540, 1610, 1620, 1640, 1690, 1730, 1750, 1760, 1820, 1940, 1950, 1970, 2310, 2480, 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(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
0 430	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide an accurate copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for five of five residents (R1, R2, R3, R4, R8). 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 the potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference, registered nurse (RN)-A stated the licensee scheduled three unlicensed staff during the morning and evening shift, and one unlicensed staff scheduled on the overnights. R1, R2, R3, R4 and R8 UDALSAs did not include an accurate number of unlicensed direct staff scheduled per shift. R1 R1's Service Contract and Lease Agreement indicated R1 started services on March 1, 2022. R1's signed copy of the UDALSA dated March 1, 2022, indicated four unlicensed staff scheduled during the morning and evening shift, and two staff scheduled on the overnights. R2 R2's Service Contract and Lease Agreement	0 430		

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0 430	Continued From page 11 indicated R2 started services on November 11, 2021. R2's UDALSA was requested, but not provided. R3 R3's Service Contract and Lease Agreement indicated R3 started services on November 6, 2021. R3's signed copy of the UDALSA dated November 6, 2021, indicated four unlicensed staff scheduled during the morning and evening shift, and two staff scheduled on the overnights. R4 R4's Service Contract and Lease Agreement indicated R4 started services on October 11, 2021. R4's signed copy of the UDALSA dated October 11, 2021, indicated four unlicensed staff scheduled during the morning and evening shift, and two staff scheduled on overnights. R8 R8's Service Contract and Lease Agreement indicated R8 started services on August 1, 2022. R8's signed copy of the UDALSA dated August 1, 2022, indicated four unlicensed staff scheduled during the morning and evening shift, and two staff scheduled on overnights. On April 13, 2022, at 3:43 p.m., RN-A stated all residents received a copy of the UDALSA form that indicated four unlicensed staff scheduled during the morning and evening shift, and two staff on the overnights. She stated the licensee needed to make an amendment as the UDALSA	0 430			

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0 430	Continued From page 12 did not accurately reflect the number of unlicensed staff scheduled daily. The licensee-provided policy titled Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated August 1, 2021, indicated the licensee would complete the UDALSA form and keep it current. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430			
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470			

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0 470	Continued From page 13 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis. This had the potential to affect all 37 residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order identified on April 11, 2022, at 2:44 p.m. Findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference with the registered nurse (RN)-A and licensed assisted living director (LALD)-B said the licensee staffed three unlicensed personnel (ULP's) during the morning and evening shifts and one staff on the overnight shift. RN-A said she was available at night if needed. RN-A said the staffing levels were based on resident acuity. During this meeting, the surveyor requested a staffing plan.	0 470		

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0 470	Continued From page 14 On April 11, 2022, at 1:55 p.m., RN-A said there were three residents which required assist of two staff members with transfers. RN-A said licensee staff called about once a week to assist staff if someone had fallen. RN-A said there was no documentation of a backup plan if RN-A was not available at night. RN-A also the licensee did not allow staff to leave during the night shift including their unscheduled break. On April 11, 2022, at 4:55 p.m., RN-A said the facility will staff two people on nights and at minimum they have the two people scheduled for the next two night shifts. The licensee's staff schedule dated April 11, 2022, through April 23, 2022, indicated one staff scheduled during the overnight shift from 10:00 p.m. to 6:30 a.m. and three staff on during the morning and evening shift. The licensee's Uniform Disclosure of Assisted Living Service Amenities (UDALSA) dated August 1, 2021, indicated four ULP's scheduled during the morning and evening shift and two staff on night shift. TIME PERIOD OF CORRECTION: Immediate The immediate order identified due to the licensee's failure to ensure sufficient staffing for all resident's 24 hours a day. The immediate order began on April 11, 2022, at 2:44 p.m., and removed on April 12, 2022, at 5:15 p.m., On April 12, 2022, noncompliance remained at a scope and severity level of F, widespread-potential for	0 470		

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0 470	Continued From page 15 harm. Based on interview and record review the licensee failed to develop, implement, and evaluate a staffing plan for appropriateness of staffing levels required as required, potentially affecting all the current residents, staff members, and visitors. In addition, the licensee also failed to ensure timely call light response. This had the potential to affect all 37 residents residing in the facility. On April 12, 2022, at 10: 45 a.m., registered nurse (RN)-A verified the licensee did not have a staffing plan. On April 12, 2022, at 10:30 a.m., R6 said she had not received a shower for 12 days due to short staffing. R6 also said her medications were late most of the time because of short staffing. The licensee's resident council meeting minutes dated April 12, 2022, indicated 8 out of 16 residents said staff members did not answer call lights in a timely manner. The same document indicated residents had concerns regarding untimely medication administration. The licensee's call light report from March 13, 2022, to April 13, 2022, indicated there were 70 call light wait times greater than 40 minutes including: April 11, 2022, at 5:23 p.m., 59 minute wait time, April 11, 2022, at 8:33 p.m., 1 hour and 13 minute wait time, April 11, 2022, at 8:36 p.m., 50 minute wait time, April 12, 2022, at 2:37 p.m., 45 minute wait time, and April 12, 2022, at 5:42 p.m., 45 minute wait time. On April 13, 2022, at 3:50 p.m., RN-A said the LALD-B and RN-A should review the call reports	0 470			

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0 470	Continued From page 16 weekly and from now on. RN-A said she expected staff to answer call lights in less than 10 minutes during the day and less than 5 minutes at night. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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: (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 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, but was not likely to	0 480		

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0 480	Continued From page 17 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates	0 490		

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0 490	Continued From page 18 opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, which create opportunities for active participation in the community at large. This had the potential to affect all 37 residents of the facility. 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: Review of the licensee's resident council minutes dated April 12, 2022, indicated residents were concerned there were no activities provided on Mondays, Fridays, Saturdays, or Sundays. The licensee's activity schedule on April 11, 2022, indicated bible study at 10:00 a.m., exercise ball at 11:30 a.m., and cards at 2:00 p.m. There were no observed activities during the day. On April 12, 2022, at 4:00 p.m., unlicensed personnel (ULP)-F said she did not work	0 490			

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0 490	Continued From page 19 Mondays and Fridays. ULP-F stated direct care staff were responsible to complete the activity schedule, but per resident council, nursing staff did not complete the activity schedule on Mondays and Fridays. On April 12, 2022, at 10:15 a.m., registered nurse (RN)-A verified activities personnel cut down to three days a week, and the licensee had not hired anyone. The DON verified the licensee should offer activities daily. The licensee-provided policy titled Activity Programming dated August 1, 2021, indicated the licensee would provide a wide range of activities and social recreation for its residents. The same document indicated the licensee would incorporate ideas suggested by the resident or family council in programming, as available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall,	0 530		

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0 530	Continued From page 20 with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a process to consider resident council recommendations and grievances. This had the potential to affect all 37 residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Resident council minutes dated January 12, 2022, at 2:00 p.m., indicated residents complained of cold, dry, and mushy food. During a meal observation on April 12, 2022, at 12:10 p.m., the surveyor asked three residents in the dining room how their food tasted, and the resident replied "cold." The licensee's lunch menu dated April 12, 2022, indicated pot roast, mashed potatoes, baby carrots, and rolls. On April 12, 2022, at 4:00 p.m., unlicensed personnel (ULP)-F said residents constantly complained about cold food during resident council meetings. On April 13, 2022, at 10:35 a.m., the licensed	0 530		

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0 530	Continued From page 21 assisted living director (LALD)-B said the temperature of the food had been a hot topic for a while. LALD-B said the cook assured her he was temping the food. LALD-B also said there was no documentation of how the licensee followed up on resident recommendations or grievances. The licensee-provided policy titled, Resident and Family Councils, dated August 1, 2021, indicated the facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council but a facility was not required to implement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required	0 550		

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0 550	Continued From page 22 content. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 lacked a posting of the grievance procedure and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On April 11, 2022, at 11:50 a.m., during the initial tour with licensed assisted living director (LALD)-B, the surveyor did not observe the licensee's posted grievance procedure. During the same tour, a posting observed with contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities in the locked entryway, which not all residents could access. On April 11, 2022, at 11:55 a.m., LALD-B verified the licensee did not have a posted grievance procedure. The licensee-provided policy titled Complaint/Grievance Posting dated August 1, 2021, indicated the licensee would post in a conspicuous place, information about the complaint/grievance procedure, and the name,	0 550		

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0 550	Continued From page 23 telephone number, and email contact information for the individual(s) who were responsible for handling resident complaint/grievances. The same policy indicated the posting would include contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all 37 residents receiving assisted living services. 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	0 580		

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
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0 580	Continued From page 24 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference, registered nurse (RN)-A and licensed assisted living director (LALD)-B both stated quality management activities were something they had been working on and planned to conduct quality management activities regularly. Both stated the licensee did not have any record or documentation of quality management activities conducted. The licensee-provided policy titled Quality Management Project dated August 1, 2021, indicated the licensee would at all times have at least one documented quality management project, and retained records of such projects for at least two years. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 620 SS=G	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all	0 620			

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0 620	Continued From page 25 cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of maltreatment for two of two residents (R8, R9) reviewed for elopement and abuse. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 R8 admitted with diagnoses including dementia with behavioral disturbance and Parkinson's syndrome. R8's service plan indicated R8 received assistance with safety checks 32 times during the day and daily reminder to bath and dress. R8's assessment dated November 8, 2021, indicated R8 was at risk for elopement and resided in a locked facility and required 30 minute safety checks. The same document indicated R8 does wander into other residents' rooms, and R8 had moderate cognitive impairment. R8's assessment dated February 7, 2022,	0 620		

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0 620	Continued From page 26 indicated R8 had impaired judgement and would smoke in the facility. The assessment also indicated R8 sees female attention by female residents as invitations for sexual advances, but R8 would not intentionally abuse someone. The same document indicated R8 does wander around the facility and will enter other resident rooms. The same document indicated R8 wrote sexually explicit notes to a female resident. Interventions included 30-minute safety checks. The same document indicated R8 signed out when he would leave the building. Elopement R8's incident report dated August 24, 2021, at 8:00 a.m., facility staff noticed R8 was not at breakfast. Facility staff checked in R8's room and the facility property. A hospice nurse noticed R8 near Journey North Church. The licensee reminded R8 to let someone know if he going to leave the property. The surveyor reviewed directions from the licensee to Journey North Church and the distance was 0.8 miles away. R8's progress notes dated March 8, 2022, indicated R8 left the building and went to a convenience store. The same document indicated law enforcement returned R8 to the facility. The same document indicated the licensee changed the door code, and R8 would require staff to get in and out of the building. On April 12, 2022, at 4:05 p.m., a surveyor observed R8 on the south side of the building near the river embankment. The surveyor and facility staff went outside and saw R8 climb back over a roped off area back to the patio.	0 620		

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0 620	Continued From page 27 R8's progress notes on April 13, 2022, indicated R8 was on the south side of the building to pick a weed. RN-A reminded R8 if he went outside, he needed to stay in the patio area. The same document indicated R8 went outside again and climbed over the rope again within a few minutes. Resident-to resident incident R8's incident report dated February 20, 2022, at 3:00 p.m., indicated staff went to assist R9 because she was crying and said she did not want to live here anymore. R9 told staff R8 pushed her in her wheelchair into her room and exposed himself to her. R8 told staff R9 asked him to do it. The licensee reminded R8 that his behavior was not appropriate. R8's progress notes dated March 3, 2022, indicated R8 asked another resident if she ever did lap dances. The licensee reminded R8 that was inappropriate. R8's medical record did not include an updated individual abuse prevention plan after R8's elopement or after the incident with R9. R9 R9 admitted to the licensee with diagnoses including diabetes, depression with anxiety, and chronic kidney disease. R9's service plan was requested, but not provided. R9's admission assessment dated February 16, 2022, indicated R9 was independent with grooming, bed mobility, and required assistance	0 620		

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0 620	Continued From page 28 with transfers, toileting, bathing, and medication administration. The assessment also indicated R9's Mental Status Questionnaire indicated R9 was cognitively intact and independent with decision making. The same document indicated R9 was not at risk for abuse by others. R9's 14-day assessment dated March 2, 2022, indicated R9's vulnerabilities included a risk to be abused by others. The intervention was staff awareness. The same document indicated R9 was easily persuaded to do things by others. R9's medical record did not include an incident report of the allegations that were made by R9 on February 20, 2022. On April 13, 2022, at 3:44 p.m., registered nurse (RN)-A said R8's elopement was not reported because she did not think R8 eloped when R8 left the facility. RN-A said in the last three to four weeks, R8 left the facility more often so a lock was placed on the south side fence by the smoking patio. RN-A said a change of condition assessment for R8 should have been completed. RN-A also said she did not report R9's claims of R8's exposing himself because no one saw it happen, and R9 was not a reliable reporter. RN-A verified the licensee did not complete internal investigations or report the incidents to MAARC. The licensee's policy, Vulnerable Adult Maltreatment- Prevention and Reporting, dated August 1, 2022, indicated the licensee prohibited the maltreatment of residents. Maltreatment was defined as neglect, abuse, and exploitation/theft and must be reported no later than 24 hours after the maltreatment was suspected. The licensee's missing resident policy dated	0 620			

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0 620	Continued From page 29 August 1, 2021, indicated when a resident was noticed to be missing a thorough search would be conducted inside and outside of the facility. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=I	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 observation, interview and record review, the licensee failed to assess or identify specific measures to reduce residents' risk of elopement while providing some residents with the door code to unmonitored key code exit doors. This affected 16 of 16 residents the facility identified as "MC" (memory care). 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	0 630		

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0 630	Continued From page 30 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A review of the resident roster indicated 16 of 37 residents identified as memory care residents. On April 11, 2022, at 10:10 a.m., during entrance conference registered nurse (RN)-A stated both memory care residents and non-memory care residents lived together in the building. RN-A stated the entire building used a key code system for entering and exiting the building. RN-A stated all the exit doors of the facility had a key code. RN-A stated memory care residents did not live in a separate secured unit. RN-A stated the facility provided the key code to some residents used to come and go from the facility. RN-A stated there was not a specific assessment used to determine which residents received the key codes. On April 11, 2022, at 12:55 p.m., the surveyor observed a resident walk in from the side patio door, the door shut halfway, opened again and stayed open approximately one minute when it shut on its own. During this observation, the surveyor saw no staff in the area. On April 11, 2022, at 1:55 p.m., RN-A stated the licensee did not have a system in place for ensuring a resident did not leave unsupervised that should not. RN-A verified a resident could leave through an open door and it was possible a resident could allow another resident to leave who did not have the key code. RN-B verified the licensee did not have facility staff that monitored the doors nor any other systems in alert staff of resident's coming and going from the facility.	0 630		

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0 630	Continued From page 31 On April 11, 2022, at 3:00 p.m., surveyors took picture of patio/river handicap door. While outside surveyors spoke to R3 who stated he had the code to go outside to smoke. During the same observation an unidentified resident walked out the door followed by followed R5. The surveyors asked R5 if she had the code, and she did not respond. R3 stated R5 did not have a code, and someone has to watch her, so she does not wander off. The surveyors observed R5 smoke on the patio with no staff members outside providing supervision with no barrier between the river and the patio. On April 11, 2022, at 3:06 p.m., ULP-C verified R5 should not be outside with staff present. On April 11, 2022, at 3:15 p.m., RN-B verified there was no specific assessment used to identify which residents had key code access and verified the IAPP did not address this issue. On April 11, 2022, at 4:55 p.m., RN-A stated the facility would change the keycode so no residents had the key code. RN-A stated the facility has a pendant system which the resident will use to request assistance exiting the building. RN-A stated the door(s) will be monitored by staff during regular business hours. TIME PERIOD OF CORRECTION: Immediate ***** ***** An immediate order was identified due to licensee's failure to assess or identify specific measures to reduce residents' risk of elopement while providing some residents with the door code to unmonitored key code exit doors. The	0 630		

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0 630	Continued From page 32 immediate order began on April 11, 2022, at 2:44 p.m., and immediacy was removed April 13, 2022, at 6:42 p.m. On April 13, 2022, noncompliance issues remained at scope and severity level of F, widespread-potential for harm. Based on interview and record review, the licensee failed to update the individual abuse prevention plan (IAPP) for 5 of 5 residents (R1, R3, R4, R8, R9) with records reviewed. The findings include: R1 R1 admitted with diagnoses included diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration including blood glucose checks. R1's progress notes dated March 8, 2022, indicated R1 was confused and wanted to go back home. The same document indicated R1 said if could not return home she would kill herself. R1's 14-day assessment dated March 16, 2022, indicated no history of self-harm or abuse. R1's medical record did not include any follow up on this incident or an updated IAPP with interventions.	0 630			

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0 630	Continued From page 33 R3 R3's diagnoses included chronic obstructive pulmonary disease and type II diabetes. R3's Service Agreement and Lease Agreement indicated R3 started services November 6, 2021. R3's assessment dated February 22, 2022, indicated R3 was oriented to person, place, time. The same assessment indicated R3 was unable to safely self-administer medications. R3's unsigned care plan dated February 22, 2022, indicated R3 required assisted with medication administration, blood glucose checks, knee brace management, cues for dressing and grooming, supervision for bathing, and used a walker. The same care plan indicated R3 was vulnerable with medication administration. R3 required assistance with medication administration including assistance with his inhaler. R3's IAPP dated February 22, 2022, indicated vulnerabilities included, but were not limited to, activities of daily living, medication management, hearing, and emergency response. The plan indicated that all medications administered by the licensee and R3 had a history of not taking medications correctly. On April 12, 2022, at 1:10 p.m., and April 13, 2022, at 7:45 a.m., a surveyor observed unlicensed personnel (ULP)-D administering oral medications to R3. On April 13, 2022, at 7:45 a.m., two inhalers were observed on R3's table. R3 stated he kept his budesonide-formoterol (Symbicort), and his Proventil HFA (albuterol) inhaler with him in his room. R3 stated he self-administered his	0 630			

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0 630	Continued From page 34 Symbicort twice daily and self-administered the Proventil HFA inhaler as needed. On April 13, 2022, at 7:45 a.m., ULP-D verified R3's medication administration record (MAR) did not indicate R3 could self-administer his Symbicort inhaler. ULP-D stated she asked R3 if he self-administered the inhaler and if he stated yes, she documented as administered on the MAR. She verified the same MAR indicated R3 self-administered the Proventil HFA inhaler. R4 R4's diagnoses included hypertension and glaucoma. R4's Service Agreement and Least Agreement indicated R4 started services October 11, 2021. R4's assessment dated January 24, 2022, indicated R4 was oriented to person, place, time, and was forgetful. The same assessment indicated R4 required one staff assist to walk and used a wheelchair to go from one location to the next. R4's signed service plan dated October 14, 2021, indicated R4 required assisted with bathing, dressing, grooming, transfers, and escorts R4's IAPP dated January 24, 2022, indicated vulnerabilities included, but were not limited to, activities of daily living, medication management, hearing, and emergency response. The plan included comments about the vulnerabilities. The plan of action for R4's risk to be abused indicated "per age" and did include specific measures to minimize risk. The same IAPP did not include	0 630			

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0 630	Continued From page 35 R4's fall risk as a vulnerability or include a plan. R4's incident report dated November 18, 2021, indicated R4 was found on the floor on his right side. The same incident report indication actions to prevent future falls included fall risk reevaluation and R4 to continue to receive Physical Therapy and Occupational Therapy services for strengthening. R4's incident report dated December 11, 2021, indicated R4's significant other helped him to the toilet, when R4 slipped. R4 sustained a skin tear/laceration. The same incident report indicated actions to prevent future falls included reminders to use call pendent and fall risk reevaluation R4's incident report dated December 28, 2021, indicated R4 was found on the floor next to his bed and sustained a left knee abrasion. The same incident report indicated actions to prevent future falls included reminders to use call pendent. R4's incident report dated January 30, 2022, indicated R4 got up from his recliner, his feet slipped out from under him and R4 hit the wall and then the floor. The same incident report indicated actions to prevent future falls included reminders to use call pendent to call for help with walking and transfers. R4's incident report dated March 26, 2022, indicated R4 fell out of bed onto the floor and was found on the floor sleeping. The same incident report indicated actions to prevent future falls included reminders to use call pendent. R4's incident report dated April 5, 2022, indicated	0 630			

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0 630	Continued From page 36 R4 rolled out of bed. The same incident report indicated actions to prevent future falls included well-being checks and fall risk reevaluation. R8 R8 admitted with diagnoses including dementia with behavioral disturbance and Parkinson's Syndrome. R8's service plan indicated R8 received assistance with safety checks 32 times during the day and daily reminder to bath and dress. R8's assessment dated February 7, 2022, indicated R8 had impaired judgement and would smoke in the facility. The assessment also indicated R8 had advancing dementia. The assessment also indicated R8 sees female attention by female resident's invitations for sexual advances, but R8 would not intentionally abuse someone. The same document indicated R8 does wander around the facility and will enter other resident's rooms. The same document indicated R8 wrote sexually explicit notes to a female resident. Interventions included 30-minute safety checks. The same document indicated R8 signed out when he would leave the building. R8's incident report dated August 24, 2021, at 8:00 a.m., facility staff noticed R8 was not at breakfast. Facility staff checked in R8's room and the facility property. A hospice nurse noticed R8 near Journey North Church. The licensee reminded R8 to let someone know if he going to leave the property. The surveyor reviewed directions from the licensee to Journey North Church and the	0 630		

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0 630	Continued From page 37 distance was 0.8 miles away. R8's progress note dated January 9, 2022, indicated an explicit sexual note was given to an employee that was a minor. The executive director told him this was not acceptable, and that behavior was not allowed. R8's progress noted dated January 12, 2022, indicated a care conference was held regarding the sexually explicit notes R8 had given to residents and staff. The notes often contained very vulgar language. R8 told staff in attendance he would stop then proceeded into singing an inappropriate song. R8's progress note dated February 2, 2022, indicated several sexually explicit notes written and signed by R8 were placed in a female resident's room. R8 agree he would no longer do this. R8's incident report dated February 20, 2022, at 3:00 p.m., indicated staff went to assist R9 because she was crying and said she did not want to live here anymore. R9 told staff R8 pushed her in her wheelchair into her room and exposed himself to her. R8 told staff R9 asked him to do it. The licensee reminded R8 that behavior was not appropriate. R8's progress note dated March 3, 2022, R8 asked another resident if she ever did lap dances. The licensee reminded R8 that was inappropriate. R8's progress notes dated March 8, 2022, indicated R8 left the building and went to a convenience store. The same document indicated law enforcement returned R8 to the facility. The same document indicated the	0 630		

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0 630	Continued From page 38 licensee changed the door code and R8 would require staff to get in and out of the building. On April 12, 2022, at 4:05 p.m., R8 was observed on the south side of the building. R8 was near the river embankment. The surveyor and a facility staff went outside and saw R8 climb back over a roped off area back to the patio. R8's progress notes on April 13, 2022, indicated R8 was on the south side of the building to pick a weed. RN-A reminded R8 if he went outside, he needed to stay in the patio area. The same document indicated R8 went outside again and climbed over the rope again within a few minutes. R8's medical record did not include an updated assessment or individual abuse prevention plan following these incidents. R9 R9 admitted to the licensee with current diagnoses including diabetes, depression with anxiety, and chronic kidney disease. R9's service plan was requested, but not provided. R9's admission assessment dated February 16, 2022, indicated R9 was independent with grooming, bed mobility, and required assistance with transfers, toileting, bathing, and medication administration. The assessment also indicated R9's Mental Status Questionnaire indicated R9 was cognitively intact and independent with decision making. The same document indicated R9 was not at risk for abuse by others. R9's 14-day assessment dated March 2, 2022,	0 630		

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0 630	Continued From page 39 indicated R9 was at risk to be abused and staff awareness was listed in the note section of the assessment. R9's progress note did not include any information related to the incident that occurred on February 20, 2022. R9's medical record did not include an incident report of the allegations that were made by R9 on February 20, 2022. An individual abuse prevention plan was requested following this incident on February 20, 2022, but was not provided. On April 13, 2022, at 3:43 p.m., registered nurse (RN)-A stated she developed the individual abuse prevention plan (IAPP) after completing her assessment. She stated after she identified vulnerabilities from R9's assessment, she developed specific measures to reduce the risk of abuse, abuse by others, or self-abuse and included those measures on the IAPP. RN-A stated R3 could safely self-administer his inhalers, and verified her assessment on February 22, 2022, indicated he could not. RN-A verified R4's assessment dated January 24, 2022, indicated R4 had a history of falls, and said R4 was at high risk for falls. RN-A verified R4 fell multiple times since admission. RN-A verified four out of the six falls' included action to prevent future falls. These actions included reminders for R4 to use his call pendent. RN-A said R4 had a pattern of falls and the fall interventions in place were no longer effective in reducing R4's risk of falls. RN-A said she needed to develop new fall interventions. RN-A also verified R1, R8, and R9, should have had updated IAPP's. The licensee-provided policy titled Individual	0 630			

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0 630	Continued From page 40 Abuse Prevention Plan dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult. The same policy indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual to include other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures taken to minimize the risk of abuse to that person or other vulnerable adults, and for the purpose of the abuse prevention plan, abuse included self-abuse. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650			

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0 650	Continued From page 41 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained a job description for one of two employees (unlicensed personnel (ULP)-D) and failed to ensure employee records contained competency testing and evaluations for two of two employees (ULP-D, ULP-E) and all other unlicensed personnel with records reviewed. 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: ULP-D ULP-D started employment on January 4, 2022. On April 12, 2022, at 11:45 a.m., the surveyor observed ULP-D checking R3's blood glucose. At	0 650		

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0 650	Continued From page 42 1:10 p.m., ULP-D was also observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., the surveyor observed ULP-D taking R3's vital signs, checking blood glucose, and administering R3's oral medications. ULP-D's record lacked documented evidence of the following required content: - a current job description, including qualifications, responsibilities and identification of staff persons providing supervision -competency evaluations ULP-E ULP-E's started employment on December 23, 2021. On April 13, 2022, at 7:49 a.m., the surveyor observed ULP-E checking R1's blood glucose, and blood pressure. During the same observation, ULP-E administered R1's oral medications and applied R1's TED stockings. ULP-E's record lacked documented evidence of competency evaluations for delegated nursing tasks. On April 13, 2022, at 12:30 p.m., the surveyor observed ULP-E completing R2's catheter care. On April 13, 2022, at 11:45 a.m., registered nurse (RN)-A stated the employee records provided to surveyors was what the licensee had for employee record content. RN-A stated she had conducted competency testing for all unlicensed personnel and said all unlicensed personnel performed a return demonstration of delegated tasks. RN-A said this training took place upon	0 650			

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0 650	Continued From page 43 hire. RN-A stated she did not record any of her competency testing or keep record of this in any of the employee records. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with	0 780		

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0 780	Continued From page 44 fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2022, between 9:00 a.m. and 10:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed smoke alarms absent in resident sleeping rooms. During the tour interview, the LALD-B explained they were unsure if the fire alarms installed on the walls functioned as smoke alarms in resident sleeping rooms. The LALD-B stated that they would follow-up with additional information. On April 15, 2022, at 2:08 p.m., the LALD-B emailed survey staff. The email explained that the licensee had received confirmation from the installer that the fire alarms in resident rooms were not smoke detector combo units. The same document indicated smoke detectors present in the hallways but not in the resident sleeping rooms. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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

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0 810	Continued From page 46 training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 12, 2022, between 10:45 a.m. and 12:15 p.m., survey staff reviewed documents, which indicated the following: 1. The Disaster Planning document dated 01-02-2022 within the Survey Readiness Binder failed to include the identification of unique or unusual resident needs for movement or evacuation. 2. The LALD-B provided employee training documentation for review on 04-12-2022. Employees completed fire safety and evacuation training upon hire and annually. Employee training on fire safety and evacuation plans did not meet the at least twice per year after hire training frequency requirement. 3. The fire drill planning matrix for 2022 indicated nine drills scheduled between April and December of 2022. The licensee did not provide documentation of drills completed before April 2022. During an interview on April 12, 2022, at 12:45 p.m., the LALD-B confirmed fire drills included evacuation procedures. The LALD-B confirmed in an email on April 13, 2022, at 5:35 p.m. the licensee had not documented drills	0 810			

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0 810	Continued From page 47 completed before April 2022, but would do so going forward. On April 12, 2022, at 12:45 p.m., the LALD-B confirmed during an interview the licensee failed to provide the required content within the fire safety and evacuation plans. LALD-B also confirmed the training frequency for employees was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced	0 930		

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0 930	Continued From page 48 by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R3, R4) and all the other residents with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference, surveyors requested a copy of the licensee's assisted living contract provided to residents from licensed assisted living director (LALD)-B. At 1:14 p.m., the surveyor reviewed a copy of the licensee provided assisted living contract titled, Rivers Edge Assisted Living Resident Contract. R3 R3's Service Agreement and Lease Agreement indicated R3 started services November 6, 2021. R3's unsigned care plan dated February 22, 2022, indicated R3 required assistance with medication administration, blood glucose checks, knee brace management, cues for dressing and grooming, supervision for bathing, and used a walker. On April 12, 2022, at 11:45 a.m., unlicensed personnel (ULP)-D was observed checking R3's	0 930		

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0 930	Continued From page 49 blood glucose. At 1:10 p.m., ULP-D was also observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., ULP-D was observed checking R3's vital signs, blood glucose, and administering R3's oral medications. R4 R4's Service Agreement and Lease Agreement indicated R4 started services October 11, 2021. R4's signed service plan dated October 14, 2021, indicated R4 required assisted with bathing, dressing, grooming, transfers, and escorts. R3 and R4's assisted living contracts did not include the following required content: -the right under section 144G.54 to appeal the termination of an assisted living contract -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent required for a transfer. On April 13, 2022, at 4:47 p.m., LALD-B verified the contract titled, Rivers Edge Assisted Living Resident Contract, was the contract used for all the residents. The licensee-provided policy titled Signing an Assisted Living Contract dated August 1, 2021, did not include information on the content of the contract. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information	0 940			

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0 940	Continued From page 50 (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 940			

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
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0 940	Continued From page 51 review, the licensee failed to execute a written contract with the required content for two of two residents (R3, R4) and all the other residents with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference surveyors requested a copy of the licensee's assisted living contract provided to residents from licensed assisted living director (LALD)-B. At 1:14 p.m., the surveyor reviewed a copy of the licensee provided assisted living contract titled, Rivers Edge Assisted Living Resident Contract. R3 R3's Service Agreement and Lease Agreement indicated R3 started services November 6, 2021. R3's unsigned care plan dated February 22, 2022, indicated R3 required assistance with medication administration, blood glucose checks, knee brace management, cues for dressing and grooming, supervision for bathing, and used a walker. On April 12, 2022, at 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-D checking R3's blood glucose. At 1:10 p.m., the surveyor observed ULP-D administering R3's oral	0 940		

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0 940	Continued From page 52 medications. On April 13, 2022, at 7:45 a.m., the surveyor observed ULP-D observed checking R3's vital signs, blood glucose, and administering R3's oral medications. R4 R4's Service Agreement and Lease Agreement indicated R4 started services October 11, 2021. R4's signed service plan dated October 14, 2021, indicated R4 required assisted with bathing, dressing, grooming, transfers, and escorts. R3 and R4's assisted living contract did not include the following required content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover	0 940		

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0 940	Continued From page 53 the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On April 13, 2022, at 4:47 p.m., LALD-B verified the contract titled, Rivers Edge Assisted Living Resident Contract, was the contract used for all the residents. The licensee-provided policy titled, Signing an Assisted Living Contract, dated August 1, 2021, did not include information on the content of the contract. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or	01330		

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01330	Continued From page 54 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to ensure one of two unlicensed personnel ((ULP)-E) completed training and competency evaluations in all required training topics. 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: ULP-E had a hire date of December 23, 2021. ULP-E's employee record lacked documentation ULP-E successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform. ULP-E's Minnesota Nursing Assistant Registry Verification of Registration expired December 13, 2013.	01330		

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01330	Continued From page 55 During an observation on April 13, 2022, at 7:49 a.m., ULP-E assisted R1 with dressing, grooming, and transferring. ULP-E was also observed checking R1's blood glucose, blood pressure, pulse, and oxygen saturation. During an observation, ULP-E administered R1's oral medications and applied R1's TED stockings. During an observation on April 13, 2022, at 12:30 p.m., ULP-E completed R2's catheter care. On April 13, 2022, at 11:45 a.m., registered nurse (RN)-A stated the employee records provided to surveyors was what the licensee had for employee record content. RN-A stated she conducted competency testing for all unlicensed personnel and said all unlicensed personnel performed a return demonstration of delegated tasks. RN-A said this training took place upon hire. RN-A stated she did not record any of her competency testing or keep record of this in any of the employee records. The licensee-provided policy titled, Competency Retraining Evaluations, dated August 1, 2021, indicated prior to unlicensed personnel providing services they must satisfactorily complete a written or oral test or practical skills test and the RN would document the competency and keep in the personnel file. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health	01420		

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01420	Continued From page 56 professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of two unlicensed personnel ((ULP)-D, ULP-E) who performed delegated tasks, and all other unlicensed personnel with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D started employment on January 4, 2022.	01420			

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01420	Continued From page 57 ULP-D's training record lacked documentation to indicate training and competency testing for knee brace application, blood glucose checks, and medication administration. On April 12, 2022, at 8:55 a.m., ULP-D stated she assisted R3 with medication administration and blood sugar checks. She also stated she assisted with knee brace application when R3 requested assistance. On April 12, 2022, at 11:45 a.m., ULP-D was observed checking R3's blood glucose. At 1:10 p.m., ULP-D was also observed administering R3's oral medications. During an observation on April 13, 2022, at 7:45 a.m., ULP-D took R3's vital signs, checked blood glucose, and administered R3's oral medications. ULP-D stated RN-A provided a class on medication administration prior to ULP-D administering to residents and said RN-A had watched her administer medications. ULP-E ULP-E's started employment on December 23, 2021. ULP-E's training record lacked documentation to indicate training and competency testing for applying TED stocking, blood glucose checks, catheter care, and medication administration. Duing an observation on April 13, 2022, at 7:49 a.m., ULP-E checked R1's blood glucose and blood pressure. ULP-E also administered R1's oral medications and applying R1's TED stockings.	01420			

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01420	Continued From page 58 On April 13, 2022, at 11:45 a.m., RN-A stated the employee records provided to surveyors was what the licensee had for employee record content. RN-A stated she conducted competency testing for all unlicensed personnel and said all unlicensed personnel performed a return demonstration of delegated tasks. RN-A said this training took place upon hire. RN-A stated she did not record any of her competency testing or keep record of this in any of the employee records. On April 13, 2022, at 12:30 p.m., ULP-E completed R2's catheter care. On April 13, 2022, at 3:43 p.m., RN-A verified R3's knee brace management was delegated to unlicensed personnel. RN-A stated unlicensed personnel assisted R3 with putting on and taking off knee braces. RN-A verified R3's record did not include instructions for the knee braces and said R3 taught the licensee staff how to put on and take off. The licensee-provided policy titled, Competency Training Evaluations, dated August 1, 2021, indicated when the RN must make certain the ULP received training and demonstrated the proper methods to perform the task or procedure TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			
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;	01470			

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01470	Continued From page 59 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this 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	01470			

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01470	Continued From page 60 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, ULP-E) received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D ULP-D started employment on January 4, 2022. During an observation on April 12, 2022, at 11:45 a.m., ULP-D checked R3's blood glucose. At 1:10 p.m., ULP-D administered R3's oral medications.	01470		

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01470	Continued From page 61 During an observation on April 13, 2022, at 7:45 a.m., ULP-D checked R3's vital signs, blood glucose, and administered R3's oral medications. ULP-E ULP-E's started employment on December 23, 2021. During an observation on April 13, 2022, at 7:49 a.m., ULP-E was observed checking R1's blood glucose and blood pressure. ULP-E also administered R1's oral medications and applied R1's TED stockings. ULP-D and ULP-E's records did not include documentation indicting the employees received orientation to include the following topics prior to providing assisted living services: - an overview of this chapter [144G] - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. - handling of emergencies and use of emergency services. - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - 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	01470		

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01470	Continued From page 62 Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On April 13, 2022, at 11:45 a.m., registered nurse (RN)-A stated the employee records provided to surveyors was what the licensee had for employee record content. The licensee provided policy dated August 1, 2021, noted all employees must complete orientation to include: - overview of the appropriate Assisted Living statutes and rules - introduction and review of the licensee's policies and procedures related to the provision of assisted living services. - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - 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 - a review of the types of assisted living services the employee would be providing and the facility's	01470		

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01470	Continued From page 63 category of licensure. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received at least eight hours of dementia care training, in the required timeframe in accordance with 144G.64 with records reviewed. 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	01540		

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01540	Continued From page 64 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D started employment on January 4, 2022. On April 12, 2022, at 11:45 a.m., the surveyor observed ULP-D checking R3's blood glucose. At 1:10 p.m., ULP-D was also observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., the surveyor observed ULP-D taking R3's vital signs, checking blood glucose, and administering R3's oral medications. ULP-D's employee record indicated ULP-D completed 3.25 hours of dementia training, with a completion date of April 12, 2022. On April 13, 2022, at 11:45 a.m., registered nurse (RN)-A stated the employee records provided to surveyors was what the licensee had for employee record content. The licensee-provided policy titled, Dementia Training, dated August 1, 2021, indicated direct care staff would complete eight hours dementia initial training within 160 hours of the employment start date. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		

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01610	Continued From page 65	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive assessment to include all areas identified on the uniform assessment tool for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a residents 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	01610		

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01610	Continued From page 66 situation has occurred only occasionally). The findings include: R1's start of care date for services was March 1, 2022. R1's diagnoses included diabetes, atrial fibrillation, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks. R1's admission assessment was completed on March 2, 2022. R1's record lacked evidence of a nursing assessment by a RN of the physical and cognitive needs of R1 on the date of admission as required. R2's start of care for services was November 11, 2022. R2's diagnoses included chronic Lyme's disease, high blood pressure, and dementia. R2's undated, unsigned service plan indicated R2 required assistance with dressing, grooming, transfers, and medication administration. R2's admission assessment was completed on November 12, 2022. R2's record lacked evidence of a nursing assessment by a RN of the physical and cognitive needs of R1 on the date of admission as required. During an interview on April 13, 2022, at 4:15 p.m., RN-A confirmed the licensee did not complete nursing assessments within the timeframe required. RN-A said the timeframe	01610		

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01610	Continued From page 67 required completion on the day of admission. The licensee-provided policy titled, Assessments, Reviews and Monitoring, dated August 1, 2021, indicated the RN would assess the physical and cognitive needs of the prospective resident. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 68 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reassessed a resident after a change in condition for one of one resident (R8) reviewed. In addition, the licensee failed to ensure a RN conducted ongoing resident monitoring and reassessment was completed for one of four residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 R8 was admitted with diagnoses including dementia with behavioral disturbance and Parkinson's Syndrome. R8's service plan dated March 1, 2022, indicated R8 required assistance with dressing, bathing, and safety checks 32 times per day. R8's incident report dated August 12, 2021, at 8:00 a.m., facility staff noticed R8 was not at breakfast. Licensee staff checked R8's room and property. R8 was located off the property by a hospice staff that was driving by. The licensee reminded R8 to let someone know if he was going to leave the property. R8's assessment dated November 8, 2021,	01620		

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01620	Continued From page 69 indicated R8 was at risk for elopement and resided in a locked facility and required 30-minute safety checks. The same document indicated R8 does wander into other resident's rooms and R8 had moderate cognitive impairment. R8's assessment dated February 7, 2022, indicated R8 had impaired judgement and would smoke in the facility. The same document also indicated R8 thought female attention was an invitation for sexual advances, but R8 would not intentionally abuse someone. The same document indicated R8 does wander around the facility and will enter other resident's rooms. The document indicated R8 had advancing dementia. The same document indicated R8 wrote sexually explicit notes to a female resident. Interventions included 30 minute safety checks. R8's mental status questionnaire indicated moderate cognitive impairment. R8's incident report dated February 20, 2022, at 3:00 p.m., indicated staff went to assist R9 because she was crying and said she did not want to live here anymore. R9 told staff R8 pushed her in her wheelchair into her room and exposed himself to her. R8 told staff R9 asked him to do it. The licensee reminded R8 that behavior was not appropriate. A review of R8's medical record indicated there were no assessments after the incidents on February 7, 2022, or February 20, 2022. R8's progress notes on March 3, 2022, a late entry indicated on March 1, 2022, R8 went to the nearby gas station and called 911, demanding the ambulance pick him up and take him to the emergency room. The same note indicated R8 called 911 told them the licensee drugged him	01620			

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01620	Continued From page 70 and he was not feeling well. R8 was taken to the emergency room and returned to the facility the same day. R8's progress notes on March 8, 2022, R8 insisted he was being poisoned and calls 911 to report this. Law enforcement had responded 13 times in the past week. The note indicated R8 has difficulty staying on task and displays flights of ideas. Later that day, R8 left the facility again and went to the gas station. Licensee staff informed R8 he required staff assistance to come and go and the door code had been changed. R8's progress notes on March 18, 2022, indicated R8 continued to have behaviors and demanded to be taken outside to smoke. On April 13, 2022, at 4:05 p.m., the surveyor observed R8 outside near the river without licensee staff. The surveyor went outside and R8 was climbing back over the roped fence on the south side of the building. R8 said he went over the rope to pick a week. The surveyor notified registered nurse (RN)-A. R8's progress notes on April 13, 2022, indicated RN-A discussed the dangers of climbing over the rope and reminded R8 of the boundaries. The same note indicated licensee staff informed R8 of the need for increased safety checks, monitoring of behaviors and need for supervision when he is outside of the building. R1 R1's start of care date for services was March 1, 2022. R1's diagnoses included Type 2 diabetes, atrial fibrillation, and congestive heart failure. R1's unsigned, undated service plan indicated R1	01620		

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01620	Continued From page 71 required assistance with all activities of daily living (ADLs), including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks. R1's 14 day assessment was completed on March 16, 2022. R1's record lacked evidence of a nursing assessment by a RN of the physical and cognitive needs of R1 on the 14th day as required. On April 13, 2022, a 3:50 p.m., RN-A said the licensee locked the north gate by the patio near the river in the last month because R8 always left the property and went to the store and called 911. RN-A said the licensee should have completed a change in condition assessment since R8 has had a lot of changes. RN-A also verified R1's 14 day assessment was not completed on the 14th day. The licensee-provided policy titled, Assessments, Reviews and Monitoring, dated August 1, 2021, indicated the RN would assess the physical and cognitive needs of the prospective resident. The same policy indicated the RN would conduct a reassessment no more than 14 calendar days after initiation of services and as needed based on changes in the needs of the resident not to exceed 90 calendar days from the last date of the assessment. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 72 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a signature or other authentication by the resident to document agreement on the services provided for three of four residents (R1, R2, R3) and failed to revise the service plan for one of two residents (R4) with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited	01640		

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01640	Continued From page 73 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's start of care date for services was March 1, 2022. R1's diagnoses included diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks. R2 R2's start of care for services was November 11, 2021. R2's diagnoses included chronic Lyme's disease, high blood pressure, and dementia. R2's undated, unsigned service plan indicated R2 required assistance with dressing, grooming, transfers and medication administration. R3 R3's diagnoses included chronic obstructive pulmonary disease and diabetes. R3's Service Agreement and Lease Agreement indicated R3 started services November 6, 2021. R3's assessment dated February 22, 2022, indicated R3 was oriented to person, place, time. R3's unsigned care plan dated February 22, 2022, indicated R3 required assistance with medication administration, blood glucose checks, knee brace management, cues for dressing and	01640		

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01640	Continued From page 74 grooming, supervision for bathing, and used a walker. On April 12, 2022, at 11:45 a.m., unlicensed personnel (ULP)-D was observed checking R3's blood glucose. At 1:10 p.m., ULP-D was observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., ULP-D observed ULP-D taking R3's vital signs, checking blood glucose, and administering R3's oral medications. R4 R4's diagnoses included hypertension and glaucoma. R4's Service Agreement and Least Agreement indicated R4 started services October 11, 2021. R4's signed service plan dated October 14, 2021, indicated R4 required assisted with bathing, dressing, grooming, transfers, and escorts. R4's assessment dated January 24, 2022, indicated R4 was oriented to person, place, time, and was forgetful. The same assessment indicated R4 required one staff assist to walk and used a wheelchair to go from one location to the next. R4's incident report dated April 5, 2022, indicated R4 rolled out of bed and sustained no injury. The same incident report indicated actions to prevent future falls included well-being checks. During entrance conference on April 11, 2022, at 10:10 a.m., registered nurse (RN)-A stated she developed and updated resident service plans after conducting an assessment. On April 13, 2022, at 10:15 a.m., RN-A verified	01640		

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01640	Continued From page 75 R1 and R2 did not have a signed service plan. On April 13, 2022, at 3:43 p.m., RN-A verified R4's assessment dated January 24, 2022, indicated R4 had a history of falls, and said R4 was at high risk for falls. RN-A verified R4 fell April 5, 2022. RN-A stated action to prevent future falls included well-being checks. RN-A stated she did not revise R4's service plan to reflect R4's well-being checks. On April 15, 2022, at 4:29 p.m., RN-A verified the licensee did not have a signed service plan for R3. The licensee-provided policy titled, Service Plan, dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and the resident, or resident representative documenting agreement on the services provided. The same policy indicated service plans required revised based on resident reassessments and monitoring. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01690 SS=C	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be	01690		

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01690	Continued From page 76 developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop written procedures for disposing of medications. The licensee's medication disposition policy and procedure had the potential to affect all residents receiving medication services. 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	01690		

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01690	Continued From page 77 or has potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, at 10:10 a.m., during the entrance conference, registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents. RN-A stated that the licensee's procedure for medication disposition required herself and a second staff to witness. RN-A stated the other licensed nurse was out on leave so herself and licensed assisted living director (LALD)-B destroyed medications together. RN-A stated the licensee's procedure was to put medications into a bag, add vinegar to dissolve, tape up the bag, and throw the bag into the garbage. She stated the licensee's new pharmacy would assist with destruction in the future, and the licensee may get a stericycle bin (pharmaceutical waste disposal bin). On April 13, 2021, at 3:43 p.m., RN-A stated the pharmacy currently used by the licensee would not take back residents unused medications. RN-A stated she did not know what the guidelines were from the Minnesota Board of Pharmacy for medication disposal. She stated dissolving unused medications in vinegar was the licensee's current practice. RN-A stated the policy and procedure needed to change and update. The licensee-provided policy titled, Medication Disposal, dated August 1, 2021, indicated the licensee would follow the guidelines of the Minnesota Board of Pharmacy for medication disposal. The procedure indicated the licensee would dispose of any discontinued or expired medications at the facility. The same document	01690			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01690	Continued From page 78 indicated the licensee would dispose of any medication remaining at the facility upon discharge, termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. The policy did not indicate the licensee's procedure for method of destruction or define how the licensee disposed of medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690			
01730 SS=D	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 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	01730			

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01730	Continued From page 79 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 and maintain a current individualized medication management plan for each resident to include all required content for one of one resident (R3) with records reviewed. 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 April 11, 2022, at 10:10 a.m., during the	01730		

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01730	Continued From page 80 entrance conference, registered nurse (RN)-A confirmed the licensee provided medication management services to residents at the facility. R3 R3's diagnoses included chronic obstructive pulmonary disease and diabetes. R3's Service and Lease Agreement indicated R3 started services November 6, 2021. R3's unsigned care plan dated February 22, 2022, indicated R3 required assistance with medication administration. On April 12, 2022, at 1:10 p.m., unlicensed personnel (ULP)-D was observed to administer R3's oral medications. On April 13, 2022, at 7:45 a.m., two inhalers observed on R3's table as well as a nebulizer machine (drug delivery device used to administer medication in the form of mist inhaled into the lungs) with a clear solution in the nebulizer reservoir. R3 stated he used the nebulizer, self-administered, and stored the nebulizer medication in his room. R3 stated he changed his own nebulizer machine's tubing when he needed to. R3 stated he kept his budesonide-formoterol (Symbicort), and his Proventil HFA (albuterol) inhaler also in his room. R3 stated he self-administered his Symbicort twice daily and self-administered the Proventil HFA inhaler as needed. On April 13, 2022, at 7:45 a.m., the surveyor observed ULP-D administer R3's oral medications. On April 13, 2022, at 7:45 a.m., ULP-D verified R3's medication administration record (MAR) did	01730			

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01730	Continued From page 81 not indicate R3 could self-administer his Symbicort inhaler. ULP-D stated she asked R3 if he administered his inhaler and if he stated yes, she documented as administered on the MAR. She verified the same MAR indicated R3 self-administered the Proventil HFA inhaler. She stated nursing had not told her R3 could self-administer the inhalers. R3's medication management plan dated February 22, 2022, indicated all medications were administered by the licensee, and R3's medications stored in the medication cart. R3 had a history of not taking medications correctly and was unable to safely self-administer medications. The medication management plan did not include R3's nebulizer machine, tubing, or medication. The same medication management plan indicated R3 needed help with inhalers and this medication task delegated to unlicensed personnel. A review of R3's undated signed prescriber orders indicated orders for budesonide-formoterol (Symbicort) and Proventil HFA (albuterol) inhaler. The same orders did not include nebulizer medication. On April 13, 2022, at 3:43 p.m., RN-A stated R3 could safely self-administer his inhalers, and verified her assessment on February 22, 2022, indicated R3 could not safely self-administer medications. RN-A stated she knew R3 had a nebulizer machine in his room. RN-A stated she did not know if R3 had prescriber orders for nebulizer medication vials, and if R3 had vials in his room R3 did not get the medication from the licensee. RN-A stated nebulizer machine tubing was replaced twice a month and said she did not know when R3's tubing was last replaced.	01730		

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01730	Continued From page 82 R3's prescriber orders for nebulizer medication were requested, but not provided. The licensee-provided policy titled, Medication Management Individualized Plan, dated August 1, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident and the record would contain the following: -a statement describing the medication management services 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 medication refills ordered on a timely basis. -identification of medication management tasks delegated to unlicensed personnel. -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 all medications administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. -The medication management record must be current and updated when there were any changes. -Medication reconciliation completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 83 The licensee-provided policy titled, Nebulizer Treatment, dated August 1, 2021, indicated the licensee remind the resident to clean the nebulizer after treatment was complete to prevent bacteria growth. The same policy indicated to remind the resident to use a new nebulizer kit and tubing every two weeks. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel ((ULP)-D, ULP-E) demonstrated competency for administering medications. 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	01750			

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01750	Continued From page 84 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 included: ULP-D ULP-D started employment on January 4, 2022. On April 12, 2022, at 1:10 p.m., ULP-D was observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., ULP-D was observed administering R3's oral medications. ULP-D's record lacked documented evidence of medication administration competency evaluation. ULP-E ULP-E started employment on December 23, 2021. On April 13, 2022, at 7:49 a.m., ULP-E was observed administering R1's oral medications. ULP-E's record lacked documented evidence of medication administration competency evaluation. On April 13, 2022, at 11:45 a.m., registered nurse (RN)-A stated the employee records provided to surveyors was what the licensee had for employee record content. RN-A stated she had conducted competency testing for all unlicensed personnel and said all unlicensed personnel performed a return demonstration of delegated tasks. RN-A said this training occurred upon hire. RN-A stated she did not record any of her	01750		

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01750	Continued From page 85 competency testing or keep record of this in any of the employee records. The licensee-provided policy titled, Delegation of Assisted Living Services, dated August 1, 2021, indicated the registered nurse would ensure prior to delegation of tasks unlicensed personnel trained and demonstrated the ability to competently follow the procedures and perform the tasks. The same policy indicated this included medication management services, medication reminders, assistance, or administration. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Surveyor: Johnson-Crosby, Erin Based on interview and record review, the licensee failed to document follow-up procedures	01760			

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01760	Continued From page 86 when the licensee did not administer medications as prescribed for one of one resident (R1) record reviewed. 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: R1's start of care date for services was March 1, 2022. R1's diagnoses included diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks. R1's March 2022 medication administration record (MAR) indicated R1 did not receive scheduled apixaban 2.5 milligrams twice daily during the morning from March 2, 2022, through March 7, 2022. R1 also did not receive the evening dose of the medication on March 1, 2022, and March 2, 2022. The medication administration summary indicated there was no supply. R1's March and April 2022 MAR indicated R1 did not receive scheduled risperidone 0.25 milligrams (mg) three times daily (8:00 a.m., 12:00 p.m., and 5:00 p.m.) as ordered from March 30, 2022, at	01760		

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01760	Continued From page 87 5:00 p.m., though April 5, 2022, at 8:00 a.m. R1's medication administration summary indicated the licensee did not administer the medications due to no supply. R1's April MAR indicated R1 did not receive scheduled Amiodarone 200 mg every day on April 3, 4, 7, and 10, 2022. R1's April 10, 2022, MAR, indicated R1 did not receive schedule morning medications including amiodarone 200 mg, calcium carbonate, divalproex 125 mg, Eliquis 2.5 mg, furosemide 20 mg, gabapentin 100 mg, metoprolol succinate 50 mg, Nystatin powder, Risperidone 0.25 mg and tamsulosin 0.4 mg. R1's medication administration summary indicated R1 did not receive these scheduled medications because she was asleep. R1's medication error reports were requested, but not provided. R1's progress notes were reviewed and did not include information related to medication errors. On April 13, 2022, at 4:25 p.m., registered nurse (RN)-A said there were no medication errors reports completed for R1 but should have been. RN-A said medication error reports should include omitted medications, and R1's provider and family should have been notified. The licensee's Medication Error policy dated August 1, 2021, indicated staff would document, track, and resolve medication administration errors for quality improvement. The person responsible for the error or who caught the error would contact the licensed nurse. The licensed nurse would contact the prescriber and family and	01760			

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01760	Continued From page 88 would document any follow up from the prescriber. The staff person would then complete a medication error report and document in the resident's record. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a current written or electronically recorded prescription for all medications the provider had managed for the licensee's three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 11, 2022, at 10:10 a.m., registered nurse (RN)-A confirmed the licensee provided medication management	01820		

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01820	Continued From page 89 services to residents at the facility. R1 R1's start of care date for services was March 1, 2022. R1's diagnoses included type 2 diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks. On April 13, 2022, at 7:49 a.m., unlicensed personnel (ULP)-E was observed administering R1's oral medications. R2 R2's start of care for services was November 11, 2021. R2's diagnoses included chronic Lyme's disease, high blood pressure, and dementia. R2's undated, unsigned service plan indicated R2 required assistance with dressing, grooming, transfers and medication administration. R3D R3's diagnoses included chronic obstructive pulmonary disease and type II diabetes. R3's Service and Lease Agreement indicated R3 started services November 6, 2021. R3's unsigned care plan dated February 22, 2022, indicated R3 required assistance with medication administration. On April 12, 2022, at 1:10 p.m., ULP-D was observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., ULP-D was	01820			

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01820	Continued From page 90 observed administering R3's oral medications. On April 13, 2022, at 7:45 a.m., the surveyor observed two inhalers on R3's table as well as a nebulizer machine (drug delivery device used to administer medication in the form of mist inhaled into the lungs) with a clear solution in the nebulizer reservoir. R3 stated he used the nebulizer, self-administered, and stored the nebulizer medication in his room. R3's undated signed prescriber orders did not include nebulizer medication. On April 13, 2022, at 10:15 a.m., RN-A confirmed multiple residents did not have current signed orders including R1, R2, and R3. The surveyor requested a list of all residents that did not have signed orders, but the licensee did not provide the list. RN-A said she sent the resident's orders to the provider this morning for signature. On April 13, 2022, at 3:43 p.m., RN-A stated she knew R3 had a nebulizer machine in his room. RN-A stated she did not know if R3 had prescriber orders for nebulizer medication vials, and if R3 had vials in his room R3 did not get the medication from the licensee. R3's prescriber orders for nebulizer medication was requested, but not provided. Pharmacy statutes 151.01 Definitions - Subd. 16b. Chart order: The chart order shall contain the name of the patient [resident] another patient identifier such as birth date or medical record number, the drug ordered, and any directions that the practitioner may prescribe concerning strength, dosage, frequency, and route of administration. The manual or electronic	01820			

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01820	Continued From page 91 signature of the practitioner must affix to the chart order at the time of writing or later in the case of verbal chart orders. The licensee-provided policy titled, Medication and Treatment Orders-Receiving, dated August 1, 2021, indicated all orders for medications required a date and signature by the prescriber and must be current and consistent with the nursing assessment. Content of the medication orders must contain the name of the drug, dosage, frequency, route, and indication and directions for use. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01940 SS=E	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	01940			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32649	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2022
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(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
01940	Continued From page 92 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: Based on interview, observation, and record review, the licensee failed to develop an individualized treatment management plan with all required content for three of three residents (R1, R2, R3) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 11, 2022, at 10:10 a.m., during an entrance conference, registered nurse (RN)-A stated the licensee provided treatment management services to residents including, but not limited to, blood glucose checks, catheter care, brace management, and oxygen assistance.	01940			

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01940	Continued From page 93 R1 R1's start of care date for services was March 1, 2022. R1's diagnoses included diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks twice daily. R1's April 2022 service recap summary indicated unlicensed personnel (ULP) had signed off and completed the task of glucose checks twice daily from April 1, 2022, through April 11, 2022. R1's record lacked evidence the RN had developed an individualized treatment management plan with the required content for blood glucose monitoring including: - documentation of specific resident instructions relating to the treatment - identification of treatment or therapy tasks delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises 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. R2 R2's start of care for services was November 11, 2021. R2's diagnoses included chronic Lyme's	01940		

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01940	Continued From page 94 disease, high blood pressure, and dementia. R2's undated, unsigned service plan indicated R2 required assistance with dressing, grooming, transfers and medication administration. R2's April 2022, recap summary indicated ULPs completed catheter care from April 1, 2022, through April 12, 2022. R2's record lacked evidence the RN had developed an individualized treatment management plan with the required content for catheter cares including: - documentation of specific resident instructions relating to the treatment - identification of treatment or therapy tasks delegated to unlicensed personnel. - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 R3's diagnoses included chronic obstructive pulmonary disease and diabetes. R3's Service and Lease Agreement indicated R3 started services November 6, 2021. R3's assessment dated February 22, 2022, did not include oxygen use. R3's unsigned care plan dated February 22, 2022, did not include oxygen use. R3's Planned	01940			

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01940	Continued From page 95 Services document undated indicated R3 received brace management and received assistance putting on and taking off knee braces. The same document did not include oxygen use. R3's Individualized Treatment and Therapy plan last updated March 25, 2022, indicated R3 received a daily blood pressure check and blood glucose checks four times day. The same Treatment and Therapy Plan did not include R3's oxygen use or knee brace application. On April 12, 2022, at 8:55 a.m., ULP-D stated she assisted R3 with knee brace application when R3 requested assistance. On April 12, 2022, at 9:55 a.m., the surveyor observed an oxygen concentrator in R3's room with attached oxygen tubing. During the same observation signage of oxygen use was not posted on R3's apartment door. On April 13, 2022, at 7:45 a.m., R3 stated he used the oxygen when his inhalers did not help him. R3 stated he used 2-3 liters of oxygen whenever he needed it and changed his own oxygen tubing when he needed to which kept in his room. R3's undated signed prescriber orders did not include orders for oxygen use. R3's undated signed Standing Orders indicated orders for oxygen 2 liters per minute via nasal cannula as needed in emergency use. R3's record lacked evidence the RN developed an individual treatment management plan with the required content for oxygen use and knee brace application including: - a statement of the type of the service provided	01940			

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01940	Continued From page 96 - documentation of specific resident instructions relating to the treatments or therapy administration - identification of treatment or therapy tasks delegated to unlicensed personnel - procedures for notifying a registered nurse when a problem arose with treatments or therapy services - 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 April 13, 2022, at 3:43 p.m., RN-A verified R3's knee brace management delegated to unlicensed personnel. RN-A stated unlicensed personnel assisted R3 with putting on and taking off knee braces. RN-A verified R3's record did not include instructions for the knee braces and said R3 taught the licensee staff how to put on and take off. RN-A stated R3 did not use oxygen. RN-A said she had not seen or told by staff R3 used oxygen. When surveyor asked where the oxygen concentrator in R3's apartment came from and why would oxygen be in R3's room if he did not use it, RN-A stated she had residents had oxygen in the past keep oxygen in the room and not use it. RN-A stated she did not assess R3 for oxygen use. RN-A verified R3's services did not include oxygen use. When asked how often staff replaced oxygen tubing, RN-A stated she believed it was once every two weeks. When asked when R3's tubing last changed RN-A stated she guessed it had never been changed. RN-A stated signage should post on resident apartment doors if oxygen was used and verified signage did not post on R3's apartment door.	01940			

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01940	Continued From page 97 On April 13, 2022, at 4:00 p.m., RN-A said R1's treatment management plan did not include blood glucose checks. RN-A also verified R2's treatment record was completed yesterday. The licensee-provided policy titled, Treatment and Therapy Management Plan, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident and should contain the following information: a statement of the service provided, documentation of specific instructions, identification of treatment or therapy tasks that will be delegated to ULPs, procedures for when to notify a nurse, resident specific requirements relating to documentation of treatment or therapy, verification all treatment and therapy was administered as prescribed, and monitoring of the treatment or therapy to prevent possible complications. The licensee-provided policy titled, Oxygen, dated August 1, 2021, indicated the licensee would determine based on assessment and the service plan if the licensee was responsible for ordering and administration of oxygen. The same policy did not include replacing oxygen tubing. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by	01950			

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01950	Continued From page 98 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) included specific instructions for resident treatments and/or therapies and documented those instructions in the resident's record for three of three residents (R1, R2, R3) with records reviewed. 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 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: R1	01950		

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01950	Continued From page 99 R1's start of care date for services was March 1, 2022. R1's diagnoses included diabetes, atrial fibrillation with rapid ventricular response, pain, and congestive heart failure. R1's unsigned, undated service plan indicated R1 required assistance with all activities of daily living (ADLs) including dressing, grooming, toileting, transfers, medication administration, and blood glucose checks twice daily. R1's April 2022 service recap summary indicated unlicensed personnel (ULP) had signed off and completed the task of glucose checks twice daily from April 1, 2022, through April 11, 2022. R1's record lacked the following content: - specified, in writing, specific instructions for the resident and documentation of those instructions in the resident's record; - communication with the ULPs about the individual needs of the resident. R2 R2's start of care for services was November 11, 2021. R2's diagnoses included chronic lymes disease, high blood pressure, and dementia. R2's undated, unsigned service plan indicated R2 required assistance with dressing, grooming, transfers and medication administration. R2's April 2022 recap summary indicated ULPs completed catheter care from April 1, 2022, through April 12, 2022. R2's record lacked the following content: - specified, in writing, specific instructions for the resident and documentation of those instructions in the resident's record;	01950		

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01950	Continued From page 100 - communication with the ULPs about the individual needs of the resident. R3 R3's diagnoses included chronic obstructive pulmonary disease and type II diabetes. R3's Service and Lease Agreement indicated R3 started services November 6, 2021. R3's Planned Services document undated indicated R3 received brace management and received assistance putting on and taking off knee braces. R3's Individualized Treatment and Therapy plan last updated March 25, 2022, did not include knee brace application. On April 12, 2022, at 8:55 a.m., ULP-D stated she assisted R3 with knee brace application when R3 requested assistance. On April 13, 2022, at 3:43 p.m., RN-A verified R3's knee brace management delegated to unlicensed personnel. RN-A stated unlicensed personnel assisted R3 with putting on and taking off knee braces. RN-A verified R3's record did not include instructions for the knee braces and said R3 taught the licensee staff how to put on and take off. On April 13, 2022, at 4:00 p.m., RN-A said R1 and R2's treatment record did not include specific instructions for blood glucose checks or catheter care. The licensee-provided policy titled, Medication and Treatment - Administration and Delegation, dated August 1, 2022, indicated when a treatment or therapy delegated or assigned to a ULP, the	01950			

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01950	Continued From page 101 RN would instruct the ULP in proper methods to each resident to perform treatment/therapy. The same policy indicated the RN would ensure the ULP had demonstrated the ability to competently follow the procedures, specified in writing specific instructions for each resident documented in the resident's record, and communicated with the ULP about the individual needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) with records reviewed. 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	01970			

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01970	Continued From page 102 only occasionally). The findings include: R3 R3's diagnoses included chronic obstructive pulmonary disease and type II diabetes. R3's Service and Lease Agreement indicated R3 started services November 6, 2021. R3's assessment dated February 22, 2022, did not include oxygen use. R3's unsigned care plan dated February 22, 2022, did not include oxygen use. R3's Planned Services document undated indicated R3 received brace management and received assistance putting on and taking off knee braces. Both documents did not include oxygen use. R3's Individualized Treatment and Therapy plan last updated March 25, 2022, did not include R3's oxygen use or knee brace application. On April 12, 2022, at 8:55 a.m., unlicensed personnel (ULP)-D stated she assisted R3 with knee brace application when R3 requested assistance. On April 12, 2022, at 9:55 a.m., an oxygen concentrator was observed in R3's room with attached oxygen tubing. On April 13, 2022, at 7:45 a.m., R3 stated he used the oxygen when his inhalers did not help him. He stated he used 2-3 liters of oxygen whenever he needed it. R3's undated signed prescriber orders did not include orders for oxygen use. R3's undated	01970		

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01970	Continued From page 103 Standing Orders indicated orders for Oxygen 2 liters per minute via nasal cannula as needed in emergency use. On April 13, 2022, at 3:43 p.m., RN-A verified R3's knee brace management delegated to unlicensed personnel. RN-A stated unlicensed personnel assisted R3 with putting on and taking off knee braces. RN-A verified R3's record did not include instructions for the knee braces and said R3 taught the licensee staff how to put on and take off. RN-A stated R3 did not use oxygen. RN-A said she had not seen or told by staff R3 used oxygen. When surveyor asked where the oxygen concentrator in R3's apartment came from and why would oxygen be in R3's room if he did not use it, RN-A stated she had residents that had oxygen in the past keep oxygen in the room and not use it. RN-A stated she did not assess R3 for oxygen use and verified R3's service plan did not include oxygen use. The licensee-provided policy titled, Medication and Treatment Orders-Receiving, dated August 1, 2021, indicated the licensee would obtain treatment orders. The same policy indicated orders for treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	144G.91 Subd. 4 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	02310		

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02310	Continued From page 104 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 a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one resident (R4) with falls with records reviewed. 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 American Journal of Nursing article titled "When a Fall Occurs" dated November 2007, volume 107, number 11, indicated fall analysis included identifying underlying causes and risk factors of the fall. Immediate follow up will help identify and enable staff to initiate preventative measures. R4 R4's diagnoses included hypertension and glaucoma. R4's Service Agreement and Least Agreement indicated R4 started services October 11, 2021. R4's assessment dated January 24, 2022, indicated R4 was oriented to person, place, time, and was forgetful. The same assessment	02310		

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02310	Continued From page 105 indicated R4 required one staff assist to walk and used a wheelchair to go from one location to the next. R4's signed service plan dated October 14, 2021, indicated R4 required assistance with bathing, dressing, grooming, transfers, and escorts. R4's IAPP dated January 24, 2022, indicated vulnerabilities included, but were not limited to, activities of daily living, medication management, hearing, and emergency response. The plan included comments about the vulnerabilities. The same IAPP did not include R4's fall risk as a vulnerability or include a plan. R4's incident report dated November 18, 2021, indicated R4 was found on the floor on his right side and did not sustain injury. The same incident report indication actions to prevent future falls included fall risk reevaluation, and R4 to continue to receive physical therapy and occupational therapy services for strengthening. R4's incident report dated December 11, 2021, indicated R4's significant other helped him to the toilet, when R4 slipped and sustained a skin tear/laceration. The same incident report indicated actions to prevent future falls included reminders to use call pendent and fall risk reevaluation R4's incident report dated December 28, 2021, indicated R4 was found on the floor next to his bed and sustained a left knee abrasion. The same incident report indicated actions to prevent future falls included reminders to use call pendent. R4's incident report dated January 30, 2022,	02310			

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02310	Continued From page 106 indicated R4 got up from his recliner, his feet slipped out from under him, hit the wall, then the floor, and did not sustain injury. The same incident report indicated actions to prevent future falls included reminders to use call pendent to call for help with walking and transfers. R4's incident report dated March 26, 2022, indicated R4 fell out of bed onto the floor, was found on the floor sleeping and did not sustain injury. The same incident report indicated actions to prevent future falls included reminders to use call pendent and indicated R4 had a handrail. R4's incident report dated April 5, 2022, indicated R4 rolled out of bed and did not sustain injury. The same incident report indicated actions to prevent future falls included well-being checks and fall risk reevaluation. On April 13, 2022, at 3:43 p.m., registered nurse (RN)-verified R4's assessment dated January 24, 2022, indicated R4 had a history of falls, and said R4 was at high risk for falls. RN-A verified R4 fell on November 18, 2021, December 11, 2021, December 28, 2021, January 30, 2022, March 26, 2022, and April 5, 2022. RN-A verified four out of the six falls included action to prevent future falls to remind R4 to use his call pendent. RN-A stated she assessed a resident after a fall and looked at the environment to prevent future falls. RN-A stated R4 had a handrail for his bed used as a grab bar to assist him from rolling out of bed or wake him up as a reminder. RN-A said R4 had a pattern of falls and the fall interventions in place were no longer effective in reducing R4's fall risk. RN-A stated she did not revise R4's service plan to reflect R4's well-being checks. RN-A stated the licensee did not track or trend falls. RN-A stated she needed to develop new fall interventions for	02310			

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02310	Continued From page 107 R4. On April 13, 2022, at 5:05 p.m., surveyors observed a handrail located on the right side of R4's bed in R4's apartment and interviewed RN-A regarding the handrail. On April 13, 2022, at 5:05 p.m., RN-A stated R4 slept on the right side of the bed. RN-A pulled on the handrail and verified the handrail as not affixed or secure. RN-A stated this was a concern. The licensee-provided policy titled, Incident Report, dated August 1, 2021, indicated incidents required reporting to the licensee. The same policy did not include the licensee's procedure specific to falls. The licensee-provided policy titled, Side rails, dated August 1, 2021, indicated use of side rails for hospital beds. The same policy did not include the licensee's policy and procedure for handrails. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by:	02480		

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02480	Continued From page 108 Based on interview and record review, the licensee failed to respond to grievances of one of one resident (R8) reviewed for grievances. In addition, the licensee failed to respond to numerous complaints from resident council. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 11, 2022, the surveyor requested the licensee's grievances. The licensees' grievances included R8's handwritten note dated November 17, 2021. This note indicated R8 was upset housekeeping removed items from his room including a maple tree, yellow weed, thistle, rocks, feather in cuts, pinecones, and agates. R8 indicated he kept his room clean, and the licensee should allow him to have things that means something to him. There was no documentation of follow up or resolution to this grievance. R8's record lacked evidence of responses to the grievance or attempts to resolve the grievance. The licensee's resident council meeting minutes dated January 12, 2022, indicated concerns including: - cleaning and laundry were not being completed. - no fire drill completed and concerns of exiting without key code	02480		

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02480	Continued From page 109 - one resident running out of medications, and staff mixing up medications. - cold and dry food. On April 12, 2022, at 4:00 p.m., unlicensed personnel (ULP)-F said the licensee did not follow up on resident concerns. ULP-F said cold food has been a concern during resident council and the licensee has not done anything to correct the concern. ULP-F said residents also voiced concerns regarding staff training and not receiving scheduled services. On April 13, 2022, at 10:35 a.m., the licensed assisted living director (LALD)-B said there was only one grievance for the last six months. LALD-B also verified there was no documentation of follow up for R8's grievance or resident concerns from resident council. LALD-B said residents should know if they have a concern to fill out the grievance form. LALD-B said follow-up on grievances should be within a week. The licensee-provided policy titled, Complaint/Grievance, dated August 1, 2021, indicated when complaints the licensee cannot easily resolved or resolve to an employee or resident's satisfaction, complete a complaint form. The same document indicated the licensee would resolve the complaint immediately whenever it possible and reasonable. The same document indicated finalized complaints go to the resident record. TIME PERIOD FOR CORRECTION: seven (7) days	02480		

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03000	Continued From page 110	03000		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	03000		

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03000	Continued From page 111 determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of maltreatment for two of two residents (R8, R9) reviewed for elopement and abuse. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 R8 admitted with diagnoses including dementia with behavioral disturbance and Parkinson's syndrome. R8's service plan indicated R8 received assistance with safety checks 32 times during the day and daily reminder to bath and	03000		

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03000	Continued From page 112 dress. R8's assessment dated November 8, 2021, indicated R8 was at risk for elopement and resided in a locked facility and required 30 minute safety checks. The same document indicated R8 does wander into other resident's rooms and R8 had moderate cognitive impairment. R8's assessment dated February 7, 2022, indicated R8 had impaired judgement and would smoke in the facility. The assessment also indicated R8 sees female attention by female resident's invitations for sexual advances, but R8 would not intentionally abuse someone. The same document indicated R8 does wander around the facility and will enter other resident's rooms. The same document indicated R8 wrote sexually explicit notes to a female resident. Interventions included 30-minute safety checks. The same document indicated R8 signed out when he would leave the building. ELOPEMENT R8's incident report dated August 24, 2021, at 8:00 a.m., facility staff noticed R8 was not at breakfast. Facility staff checked in R8's room and the facility property. A hospice nurse noticed R8 near Journey North Church. The licensee reminded R8 to let someone know if he going to leave the property. The surveyor reviewed directions from the licensee to Journey North Church and the distance was 0.8 miles away. R8's progress notes dated March 8, 2022, indicated R8 left the building and went to a	03000		

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03000	Continued From page 113 convenience store. The same document indicated law enforcement returned R8 to the facility. The same document indicated the licensee changed the door code and R8 would require staff to get in and out of the building. On April 12, 2022, at 4:05 p.m., a surveyor observed R8 on the south side of the building near the river embankment. The surveyor and facility staff went outside and saw R8 climb back over a roped off area back to the patio. R8's progress notes on April 13, 2022, indicated R8 was on the south side of the building to pick a weed. RN-A reminded R8 if he went outside, he needed to stay in the patio area. The same document indicated R8 went outside again and climbed over the rope again within a few minutes. Resident-to-resident incident R8's incident report dated February 20, 2022, at 3:00 p.m., indicated staff went to assist R9 because she was crying and said she did not want to live here anymore. R9 told staff R8 pushed her in her wheelchair into her room and exposed himself to her. R8 told staff R9 asked him to do it. The licensee reminded R8 that behavior was not appropriate. R8's progress notes dated March 3, 2022, R8 asked another resident if she ever did lap dances. The licensee reminded R8 that was inappropriate. R8's medical record did not include an updated individual abuse prevention plan after R8's elopement or after the incident with R9.	03000		

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03000	Continued From page 114 R9 R9 admitted to the licensee with diagnoses including type diabetes, depression with anxiety and chronic kidney disease. R9's service plan was requested, but not provided. R9's admission assessment dated February 16, 2022, indicated R9 was independent with grooming, bed mobility, and required assistance with transfers, toileting, bathing, and medication administration. The assessment also indicated R9's Mental Status Questionnaire indicated R9 was cognitive and independent with decision making. The same document indicated R9 was not at risk for abuse by others. R9's 14-day assessment dated March 2, 2022, indicated R9's vulnerabilities included a risk to be abused by others. The intervention was staff awareness. The same document indicated R9 was easily persuaded to do things by others. R9's medical record did not include an incident report of the allegations that were made by R9 on February 20, 2022. On April 13, 2022, at 3:44 p.m., registered nurse (RN)-A said R8's elopement was not reported because she did not think R8 eloped when R8 left the facility. RN-A said in the last three to four weeks R8 left the facility more often so a lock was placed on the south side fence by the smoking patio. RN-A said a change of condition assessment for R8 should have been completed. RN-A also said she did not report R9's claims of R8's exposing himself because no one saw it happen and R9 was not a reliable reporter. RN-A verified the licensee did not complete internal	03000			

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03000	Continued From page 115 investigations or report the incidents to MAARC. The licensee's policy Vulnerable Adult Maltreatment- Prevention and Reporting, dated August 1, 2022, indicated the licensee prohibited the maltreatment of residents. Maltreatment was defined as neglect, abuse, and exploitation/theft and must be reported no later than 24 hours after the maltreatment was suspected. The licensee's missing resident policy dated August 1, 2021, indicated when a resident was noticed to be missing a thorough search would be conducted inside and outside of the facility. TIME PERIOD FOR CORRECTION: Seven (7) days	03000			