Electronically Delivered

May 31, 2024

Licensee
River Oaks at Watertown
409 Jefferson Avenue Southwest
Watertown, MN 55388

RE: Project Number(s) SL34299015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34299	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34299015 On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 47 resident(s); 44 receiving services under the provider's Assisted Living license. ********REVISED******** The state form has been revised to remove tag 0480, as no violations were cited on the Food and Beverage Report.	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.	
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 1 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 appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 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: During the entrance conference on April 29, 2024, at 10:10 a.m. licensed assisted living director (LALD)-A, she had been out for 12 weeks on maternity leave and quality management meetings were not held while she was gone and	0 580		

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0 580	Continued From page 2 have not been completed since she came back. The Quality Meeting minutes were reviewed and had not been completed since March 31, 2023. The licensee's Quality Management Plan policy dated July 20, 2021, indicated quality council meetings will be held at least quarterly to evaluate the quality of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 780 SS=E	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	0 780		

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0 780	Continued From page 3 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 functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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, 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 29, 2024, at 11:00 a.m., survey staff toured the facility with the maintenance staff (M)-D. During the tour survey staff observed the following: 1. Apartments #101 - #111 did not have smoke alarms installed in the bedrooms. 2. Apartments #101 - #111 did not have interconnected smoke alarms installed. 3. There was no smoke alarm outside and in the immediate vicinity of the sleeping area in "dormitories" #3, #4, #6, #7, and #8.	0 780		

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0 780	Continued From page 4 During interview on April 29, 2024, at 12:30 p.m. M-D stated he understood the deficiencies and would have new smoke alarms installed and interconnected in the above locations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 790		

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0 790	Continued From page 5 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 29, 2024, at 11:00 a.m., survey staff toured the facility with the maintenance staff (M)-D. It was observed that the portable fire extinguishers throughout the facility were past due for their annual inspection and certification. All fire extinguishers were observed having a maintenance tag with the last inspection date of February 2023. Documentation is required to demonstrate fire extinguishers have been annually serviced by a certified technician. During interview on April 29, 2024, at 12:30 p.m., M-D stated that he didn't realize the fire extinguishers were past due for their annual inspection and certification. He stated he would have their fire safety contractor out as soon as possible to do the maintenance. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 810		

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0 810	Continued From page 6 (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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 7 or has potential to affect a large portion or all of the residents). The findings include: During observation on April 29, 2024, at 11:00 a.m., the surveyor observed the fire evacuation diagrams did not include the correct room numbers for each bedroom. Posted evacuation plans were numbered and labeled, but the numbers and labels did not match the identification plaques located next to each room and ancillary space throughout the facility. On January 3, 2024, the registered nurse (RN)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Internal", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan also stated to evacuate residents from upstairs and downstairs. The facility was a single story with an unoccupied, unfinished basement. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have an occupied lower level. The FSEP did not identify specific fire protection	0 810		

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0 810	Continued From page 8 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated they had not had an opportunity to update the policy to make it site-specific. The policy reviewed was developed by their corporate office and did not include site-specific procedures. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided documents indicated one training was completed on February 06, 2024. RN-E was unable to provide documentation showing a second training was provided for staff on the fire safety and evacuation plan. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated she understood the requirements and would implement a training program that was compliant with statute requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that drills were completed on 2/27/23, 3/31/23, 4/26/23, and 2/2/24. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated they had staffing difficulties in 2023 and had recently hired a new director of maintenance who was in the process of getting	0 810		

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0 810	Continued From page 9 the evacuation drills back on schedule. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 10 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for two of two residents (R4, R5) who were hospitalized. 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: R4 R4 began receiving services from the licensee on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received assistance with activities of daily living (ADLs) and medication management.	01060		

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01060	Continued From page 11 R4 was hospitalized December 25, 2023, through December 28, 2023, and again March 24, 2024, through April 8, 2024. R4's record contained an emergency notification form to the ombudsman dated December 25, 2023; however, R4's record lacked evidence emergency notification was completed for the March 24, 2024, admission to the hospital. R5 R5 began receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8,2023, indicated R5 received assistance with ADLs and medication management. R5 was hospitalized April 10, 2024, through April 16, 2024, and again April 22, 2024, through April 26, 2024. R5's record contained an emergency notification form to the ombudsman dated April 22, 2024; however, R5's record lacked evidence emergency notification was completed for the April 10, 2024, admission to the hospital. On April 30, 2024, at 1:55 p.m. vice president of operations (VPO)-F stated they were only able to find one emergency relocation for R4 and could not find one completed for the March 2024 hospital admission. VPO-F also stated she could only find one of R5's two hospital stays. VPO-F stated their process is a social worker sends a notification out, but these must have been missed.	01060		

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01060	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 a face-to-face medication management reassessment to include all required content for three of four residents (R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services from the licensee on	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34299	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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
01710	Continued From page 13 May 6, 2019, with a diagnosis of anoxic brain damage, diabetes, and major depressive disorder. R4's service plan dated March 13, 2023, indicated R2 received medication management. R2's record included an annual medication reassessment completed February 24, 2023. R2's record lacked evidence of any further medication reassessments. R2's March 2024, electronic medication administration record (MAR) included the following medications: Carbamazepine 100 mg (milligrams) used to treat epilepsy. Insulin Aspart Flex pen 100 units used for diabetes. Lantus Insulin 16 units used for diabetes. levetiraceta 250 mg used to control seizures. R4 R4 began receiving services on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received medication management. R4's record included an annual medication reassessment completed February 23, 2023. R4's record lacked evidence of any further medication reassessments. R4's March 2024, MAR included the following medications: amlodipine 10 mg. Used to treat high blood pressure. clonazepam 1 mg Used for anxiety.	01710		

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01710	Continued From page 14 ferrosol 325 mg is an iron supplement. furosemide 40 mg used to treat high blood pressure. Metformin 500 mg used for diabetes. olanzapine 20 mg used in the treatment of schizophrenia. R5 R5 Started receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8,2023, indicated R5 received assistance with medication management. R5's record included an annual medication reassessment completed March 13, 2023. R5's record lacked evidence of any further medication reassessments. R5's March 2024, MAR included the following medications: acetaminophen 500 mg for pain control. Eliquis 5 mg used to prevent stroke. Ferrous Sulfate 220 mg for iron supplement. Gabapentin 300 mg for pain control. olanzapine 2.5 mg used as an antipsychotic. Vitamin C 500 mg for vitamin supplement On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated that annual medication and treatment assessments are completed annually; however, they have not yet been completed for 2024. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy revised January 23, 2022, indicated the RN will document the services the client will receive	01710		

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01710	Continued From page 15 on the client's individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 16 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's March 2024, electronic medication administration record (MAR) included: Blood sugar (BS) check four times a day (7:30 a.m., 11:30 a.m., 4:30 p.m., 7:30 p.m.) Insulin Aspart Flex Pen 100 units/ml (milliliter)-inject 11 units before lunch plus sliding scale. For BS less than 200 - no additional units BS 201-300 = 1 additional unit BS 301 and greater = 2 additional units On April 29, 2024, at 11:45 a.m. director of nursing (DON)-G asked unlicensed personnel (ULP)-H for the keys to the medication cart to check R2's blood sugar and administer insulin. On April 29, 2024, at 12:29 p.m. ULP-H reviewed the blank entry for blood sugar and insulin in the EMAR and called DON-G to confirm. DON-G stated the blood sugar was 156 and she gave 3 units of insulin according to a sticky note on R2's medication box. DON-G directed ULP-H to give an additional 8 units of insulin to equal the required 11 units in the EMAR. ULP-H was observed drawing up 8 units of insulin and asked registered nurse (RN)-E to confirm dosage and to record 11 units drawn up instead of 8 units. ULP-H administered insulin and documented administering 11 units instead of 8 units. On April 30, 2024, at 1:30 p.m. RN-C and president of clinical operations (PCO)-B, stated the medication error occurred because the nurse did not look at the EMAR and did not document after giving insulin.	01760		

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01760	Continued From page 17 The licensee's Documentation of Medication, Treatment and Therapy Management Services policy revised January 23, 2022, indicated staff will document each task immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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:	01830		

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01830	Continued From page 18 R4 R4 began receiving services from the licensee on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received medication management. R4's March 2024, medication administration record (MAR) included the following medications: amlodipine 10 mg used to treat high blood pressure. clonazepam 1 mg used for anxiety. ferrosol 325 mg used as an iron supplement. furosemide 40 mg used to treat high blood pressure. Metformin 500 mg used for diabetes. olanzapine 20 mg used in the treatment of schizophrenia. R4's record included physician orders dated April 12, 2023. R4's record lacked evidence of signed annual renewal of medications. R5 R5 began receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8, 2023, indicated R5 received services including medication management. R5's March 2024, MAR included the following medications: acetaminophen 500 mg for pain control.	01830		

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01830	Continued From page 19 Eliquis 5 mg used to prevent stroke. ferrous sulfate 220 mg used as an iron supplement. Gabapentin 300 mg used for pain control. olanzapine 2.5 mg used as an antipsychotic. Vitamin C 500 mg used as a vitamin supplement R5's record included physician orders dated February 16, 2023. R5's record lacked evidence of signed annual renewal of medications. On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated annual physician orders are usually obtained, but the files were missing current physician orders. The licensee's initial and on-going nursing assessment of residents under the comprehensive licensed agency policy dated July 26, 2021, indicated the resident record should include orders or prescriptions for medications, treatments, or therapies that the agency will be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	01910		

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01910	Continued From page 20 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's prescription number, as applicable, and to whom the medications were given for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on October 12, 2021, with a diagnosis of schizoaffective disorder and discharged to	01910		

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01910	Continued From page 21 another facility on February 22, 2024. R1's physician order sheet dated August 25, 2023, identified R1 took the following medications: Allopurinol 100 mg (milligrams) for gout Atorvastatin 20 mg for high cholesterol Calcium vitamin supplement Clozapine 100 mg for schizoaffective disorder Gabapentin 600 mg for pain Glipizide 10 mg for diabetes R1's record contained a medication disposition form dated August 12, 2023, that lacked a prescription number (RX) and amount of medication. R1's record failed to show evidence of a medication disposition form for the last discharge date of February 22, 2024. On April 30, 2024, at 9:50 a.m. president of clinical operations (PCO)-B, stated the facility was aware of the process and stated the staff did not fill it out correctly. PCO-B could not explain the date of the medication disposition form being August 12, 2023, when the discharge was on February 22, 2024. The licensee's Resident Records policy dated July 26, 2021, indicated the resident record would contain a discharge summary, including service termination notice and related documentation when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01970	Continued From page 22	01970		
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 interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on April 29, 2024, at 10:10 a.m. president of clinical operations (PCO)-B, stated the licensee provided treatment and therapy services to residents. R2 began receiving services from the licensee on May 6, 2019, with a diagnosis of anoxic brain damage, diabetes, and major depressive	01970		

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01970	Continued From page 23 disorder. R2's service plan last updated March 25, 2024, indicated R2 received assistance with blood sugar checks twice a day. R2's record included physician orders dated February 24, 2023. R2's record included an individualized treatment and therapy plan completed March 3, 2023. On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated that annual physician orders are usually obtained, but R2's record was missing orders. The licensee's initial and on-going nursing assessment of residents under the comprehensive licensed agency policy dated July 26, 2021, indicated the resident record should include orders or prescriptions for medications, treatments, or therapies that the agency will be managing. It did not indicate orders wee required to be updated at least yearly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL34299015 On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 47 resident(s); 44 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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	0 580		

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0 580	Continued From page 2 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 appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 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: During the entrance conference on April 29, 2024, at 10:10 a.m. licensed assisted living director (LALD)-A, she had been out for 12 weeks on maternity leave and quality management meetings were not held while she was gone and have not been completed since she came back.	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT WATERTOWN	409 JEFFERSON AVENUE SW WATERTOWN, MN 55388

(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
0 580	Continued From page 3 The Quality Meeting minutes were reviewed and had not been completed since March 31, 2023. The licensee's Quality Management Plan policy dated July 20, 2021, indicated quality council meetings will be held at least quarterly to evaluate the quality of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 780 SS=E	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	0 780		

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0 780	Continued From page 4 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 functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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, 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 29, 2024, at 11:00 a.m., survey staff toured the facility with the maintenance staff (M)-D. During the tour survey staff observed the following: 1. Apartments #101 - #111 did not have smoke alarms installed in the bedrooms. 2. Apartments #101 - #111 did not have interconnected smoke alarms installed. 3. There was no smoke alarm outside and in the immediate vicinity of the sleeping area in "dormitories" #3, #4, #6, #7, and #8. During interview on April 29, 2024, at 12:30 p.m. M-D stated he understood the deficiencies and	0 780		

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0 780	Continued From page 5 would have new smoke alarms installed and interconnected in the above locations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 790		

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0 790	Continued From page 6 of the residents). The findings include: On April 29, 2024, at 11:00 a.m., survey staff toured the facility with the maintenance staff (M)-D. It was observed that the portable fire extinguishers throughout the facility were past due for their annual inspection and certification. All fire extinguishers were observed having a maintenance tag with the last inspection date of February 2023. Documentation is required to demonstrate fire extinguishers have been annually serviced by a certified technician. During interview on April 29, 2024, at 12:30 p.m., M-D stated that he didn't realize the fire extinguishers were past due for their annual inspection and certification. He stated he would have their fire safety contractor out as soon as possible to do the maintenance. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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 7 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 8 The findings include: During observation on April 29, 2024, at 11:00 a.m., the surveyor observed the fire evacuation diagrams did not include the correct room numbers for each bedroom. Posted evacuation plans were numbered and labeled, but the numbers and labels did not match the identification plaques located next to each room and ancillary space throughout the facility. On January 3, 2024, the registered nurse (RN)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Internal", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan also stated to evacuate residents from upstairs and downstairs. The facility was a single story with an unoccupied, unfinished basement. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have an occupied lower level. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic	0 810		

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0 810	Continued From page 9 evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated they had not had an opportunity to update the policy to make it site-specific. The policy reviewed was developed by their corporate office and did not include site-specific procedures. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided documents indicated one training was completed on February 06, 2024. RN-E was unable to provide documentation showing a second training was provided for staff on the fire safety and evacuation plan. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated she understood the requirements and would implement a training program that was compliant with statute requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated that drills were completed on 2/27/23, 3/31/23, 4/26/23, and 2/2/24. During an interview on April 29, 2024, at 12:30 p.m., RN-E stated they had staffing difficulties in 2023 and had recently hired a new director of maintenance who was in the process of getting the evacuation drills back on schedule.	0 810		

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0 810	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 11 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for two of two residents (R4, R5) who were hospitalized. 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: R4 R4 began receiving services from the licensee on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received assistance with activities of daily living (ADLs) and medication management. R4 was hospitalized December 25, 2023, through	01060		

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01060	Continued From page 12 December 28, 2023, and again March 24, 2024, through April 8, 2024. R4's record contained an emergency notification form to the ombudsman dated December 25, 2023; however, R4's record lacked evidence emergency notification was completed for the March 24, 2024, admission to the hospital. R5 R5 began receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8,2023, indicated R5 received assistance with ADLs and medication management. R5 was hospitalized April 10, 2024, through April 16, 2024, and again April 22, 2024, through April 26, 2024. R5's record contained an emergency notification form to the ombudsman dated April 22, 2024; however, R5's record lacked evidence emergency notification was completed for the April 10, 2024, admission to the hospital. On April 30, 2024, at 1:55 p.m. vice president of operations (VPO)-F stated they were only able to find one emergency relocation for R4 and could not find one completed for the March 2024 hospital admission. VPO-F also stated she could only find one of R5's two hospital stays. VPO-F stated their process is a social worker sends a notification out, but these must have been missed. No further information was provided.	01060		

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01060	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 a face-to-face medication management reassessment to include all required content for three of four residents (R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services from the licensee on May 6, 2019, with a diagnosis of anoxic brain damage, diabetes, and major depressive	01710		

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01710	Continued From page 14 disorder. R4's service plan dated March 13, 2023, indicated R2 received medication management. R2's record included an annual medication reassessment completed February 24, 2023. R2's record lacked evidence of any further medication reassessments. R2's March 2024, electronic medication administration record (MAR) included the following medications: Carbamazepine 100 mg (milligrams) used to treat epilepsy. Insulin Aspart Flex pen 100 units used for diabetes. Lantus Insulin 16 units used for diabetes. levetiraceta 250 mg used to control seizures. R4 R4 began receiving services on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received medication management. R4's record included an annual medication reassessment completed February 23, 2023. R4's record lacked evidence of any further medication reassessments. R4's March 2024, MAR included the following medications: amlodipine 10 mg. Used to treat high blood pressure. clonazepam 1 mg Used for anxiety. ferrosol 325 mg is an iron supplement. furosemide 40 mg used to treat high blood	01710		

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01710	Continued From page 15 pressure. Metformin 500 mg used for diabetes. olanzapine 20 mg used in the treatment of schizophrenia. R5 R5 Started receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8,2023, indicated R5 received assistance with medication management. R5's record included an annual medication reassessment completed March 13, 2023. R5's record lacked evidence of any further medication reassessments. R5's March 2024, MAR included the following medications: acetaminophen 500 mg for pain control. Eliquis 5 mg used to prevent stroke. Ferrous Sulfate 220 mg for iron supplement. Gabapentin 300 mg for pain control. olanzapine 2.5 mg used as an antipsychotic. Vitamin C 500 mg for vitamin supplement On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated that annual medication and treatment assessments are completed annually; however, they have not yet been completed for 2024. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy revised January 23, 2022, indicated the RN will document the services the client will receive on the client's individualized medication management plan.	01710		

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01710	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01760		

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01760	Continued From page 17 situation has occurred only occasionally). The findings include: R2's March 2024, electronic medication administration record (MAR) included: Blood sugar (BS) check four times a day (7:30 a.m., 11:30 a.m., 4:30 p.m., 7:30 p.m.) Insulin Aspart Flex Pen 100 units/ml (milliliter)- inject 11 units before lunch plus sliding scale. For BS less than 200 - no additional units BS 201-300 = 1 additional unit BS 301 and greater = 2 additional units On April 29, 2024, at 11:45 a.m. director of nursing (DON)-G asked unlicensed personnel (ULP)-H for the keys to the medication cart to check R2's blood sugar and administer insulin. On April 29, 2024, at 12:29 p.m. ULP-H reviewed the blank entry for blood sugar and insulin in the EMAR and called DON-G to confirm. DON-G stated the blood sugar was 156 and she gave 3 units of insulin according to a sticky note on R2's medication box. DON-G directed ULP-H to give an additional 8 units of insulin to equal the required 11 units in the EMAR. ULP-H was observed drawing up 8 units of insulin and asked registered nurse (RN)-E to confirm dosage and to record 11 units drawn up instead of 8 units. ULP-H administered insulin and documented administering 11 units instead of 8 units. On April 30, 2024, at 1:30 p.m. RN-C and president of clinical operations (PCO)-B, stated the medication error occurred because the nurse did not look at the EMAR and did not document after giving insulin. The licensee's Documentation of Medication,	01760		

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	34299	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 18 Treatment and Therapy Management Services policy revised January 23, 2022, indicated staff will document each task immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R4	01830		

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	34299	A. BUILDING: _____ B. WING _____	05/01/2024

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01830	Continued From page 19 R4 began receiving services from the licensee on December 20, 2021, with a diagnosis of schizoaffective disorder. R4's service plan dated February 22, 2024, indicated R4 received medication management. R4's March 2024, medication administration record (MAR) included the following medications: amlodipine 10 mg used to treat high blood pressure. clonazepam 1 mg used for anxiety. ferrosol 325 mg used as an iron supplement. furosemide 40 mg used to treat high blood pressure. Metformin 500 mg used for diabetes. olanzapine 20 mg used in the treatment of schizophrenia. R4's record included physician orders dated April 12, 2023. R4's record lacked evidence of signed annual renewal of medications. R5 R5 began receiving services from the licensee on November 16, 2021, with a diagnosis of paraplegia and major depressive disorder. R5's service plan dated March 8, 2023, indicated R5 received services including medication management. R5's March 2024, MAR included the following medications: acetaminophen 500 mg for pain control. Eliquis 5 mg used to prevent stroke. ferrous sulfate 220 mg used as an iron	01830		

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01830	Continued From page 20 supplement. Gabapentin 300 mg used for pain control. olanzapine 2.5 mg used as an antipsychotic. Vitamin C 500 mg used as a vitamin supplement R5's record included physician orders dated February 16, 2023. R5's record lacked evidence of signed annual renewal of medications. On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated annual physician orders are usually obtained, but the files were missing current physician orders. The licensee's initial and on-going nursing assessment of residents under the comprehensive licensed agency policy dated July 26, 2021, indicated the resident record should include orders or prescriptions for medications, treatments, or therapies that the agency will be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.	01910		

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	34299	A. BUILDING: _____ B. WING _____	05/01/2024

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01910	Continued From page 21 (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's prescription number, as applicable, and to whom the medications were given for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 started receiving services from the licensee on October 12, 2021, with a diagnosis of schizoaffective disorder and discharged to another facility on February 22, 2024.	01910		

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01910	Continued From page 22 R1's physician order sheet dated August 25, 2023, identified R1 took the following medications: Allopurinol 100 mg (milligrams) for gout Atorvastatin 20 mg for high cholesterol Calcium vitamin supplement Clozapine 100 mg for schizoaffective disorder Gabapentin 600 mg for pain Glipizide 10 mg for diabetes R1's record contained a medication disposition form dated August 12, 2023, that lacked a prescription number (RX) and amount of medication. R1's record failed to show evidence of a medication disposition form for the last discharge date of February 22, 2024. On April 30, 2024, at 9:50 a.m. president of clinical operations (PCO)-B, stated the facility was aware of the process and stated the staff did not fill it out correctly. PCO-B could not explain the date of the medication disposition form being August 12, 2023, when the discharge was on February 22, 2024. The licensee's Resident Records policy dated July 26, 2021, indicated the resident record would contain a discharge summary, including service termination notice and related documentation when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01970	Continued From page 23	01970		
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 interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on April 29, 2024, at 10:10 a.m. president of clinical operations (PCO)-B, stated the licensee provided treatment and therapy services to residents. R2 began receiving services from the licensee on May 6, 2019, with a diagnosis of anoxic brain damage, diabetes, and major depressive disorder.	01970		

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01970	Continued From page 24 R2's service plan last updated March 25, 2024, indicated R2 received assistance with blood sugar checks twice a day. R2's record included physician orders dated February 24, 2023. R2's record included an individualized treatment and therapy plan completed March 3, 2023. On April 30, 2024, at 11:15 a.m. registered nurse (RN)-C stated that annual physician orders are usually obtained, but R2's record was missing orders. The licensee's initial and on-going nursing assessment of residents under the comprehensive licensed agency policy dated July 26, 2021, indicated the resident record should include orders or prescriptions for medications, treatments, or therapies that the agency will be managing. It did not indicate orders wee required to be updated at least yearly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *05/01/24*
Time: 10:00:00
Report: 8087241115

Food and Beverage Establishment Inspection Report

Location:
River Oaks At Watertown
409 Jefferson Avenue Sw
Watertown, MN55388
Carver County, 10

Establishment Info:
ID #: 0039392
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529552054
ID #:

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

No NEW orders were issued during this inspection.

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

INSPECTION DONE IN THE PRESENCE OF NURSE EVALUATOR TRACEY FEARON. FACILITY USES A THIRD PARTY TO OPERATE KITCHEN AND NUTRITION PROGRAM SO NO INSPECTION WAS CONDUCTED. LICENSE HAS BEEN ISSUED TO HEALTHCARE SERVICES, THE CONTRACTED PARTY AND A KITCHEN INSPECTION WILL BE COMPLETED IN THE NEAR FUTURE. NO ORDERS WRITTEN TODAY.

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 8087241115 of 05/01/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
HANNAH SUPAN
KITCHEN MANAGER

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us