Electronically Delivered

January 15, 2025

Licensee
Riverside Assisted Living
885 Meadowview Circle North
Pillager, MN 56473

RE: Project Number(s) SL27489016

Dear Licensee:

On December 31, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 6, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

December 12, 2024

Licensee
Riverside Assisted Living
885 Meadowview Circle North
Pillager, MN 56473

RE: Project Number(s) SL27489016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 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.

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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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), 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

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.

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

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. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27489	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE ASSISTED LIVING	885 MEADOWVIEW CIRCLE NORTH PILLAGER, MN 56473

(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 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: SL27489016-0 On November 4, 2024, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility license. An immediate correction order was identified on November 5, 2024, issued for SL27896016-0, tag identification 1290. On November 6, 2024, at 8:51 a.m.., the licensee provided actions to the surveyor supervisor to mitigate the immediacy of correction order 1290, however, non-compliance remained at a scope and level of I.	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 SS=F	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 November 6, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents:	0 485		

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0 485	Continued From page 2 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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 November 4, 2024, at 10:59 a.m., licensed assisted living	0 485		

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0 485	Continued From page 3 director (LALD)-A stated the licensee provided residents three meals per day and the licensee offered a meal plan option on "Addendum C." On page three of the [licensee name] Assisted Living Contract, 7. Services Available Through Provider; Fees c. Access to Food: Meal Plans indicated meals are included in the monthly rent. On Attachment C: Meal Plan Addendum offered a resident the following options: -I (resident) would like to participate in the Community's [sic] monthly meal plan. I understand this includes 3 (three) meals per day at the rate listed above; and -I (resident) do not want to participate in the Community's [sic] monthly meal plan. I (resident) understand that I (resident) will not receive any meals through Provider [sic], that a la carte meals are not available at the Community [sic] and that I (resident) will be responsible for providing all of my own meals which also includes coordination of food delivery and any and all related expenses. Resident assisted living contracts and contract addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On November 5, 2024, at 12:06 p.m., LALD-D stated the licensee offered residents to be charged for three meals per day or no meals at all. LALD-A further stated the licensee was aware of allowing residents to opt out of meals, however, the licensee was still in discussion about how to implement the change. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October	0 485		

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0 485	Continued From page 4 15, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of two employees (unlicensed personnel (ULP)-G, ULP-H) during medication and treatment administration. 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	0 510		

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0 510	Continued From page 5 or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on November 4, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. ULP-G On November 5, 2024, at 6:46 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R6, then ULP-G returned to the computer to document in R6's electronic medication administration record (EMAR). The surveyor did not observe ULP-G complete hand hygiene before or after medication administration for R6. On November 5, 2024, at 6:58 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R8, then ULP-G returned to the computer to document in R8's EMAR. The surveyor did not observe ULP-G complete hand hygiene before or after medication administration for R8. On November 5, 2024, at 8:24 a.m., the surveyor observed ULP-G complete scheduled blood glucose check for R2. ULP-G donned (put on) gloves, cleaned R2's left pointer finger, poked R2's finger, wiped blood off R2's finger, squeezed R2's finger, and took the blood sample for the blood glucose reading. ULP-G doffed (took off) gloves, returned to the medication cart, fixed the garbage bag on the medication cart, and proceeded to document on R2's EMAR. The surveyor did not observe ULP-G complete hand hygiene before or after donning/doffing gloves.	0 510		

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0 510	Continued From page 6 On November 5, 2024, at 10:46 a.m., ULP-G stated ULP-G was "behind today" and ULP-G did not complete hand hygiene as trained. ULP-G further stated ULP-G typically completed hand hygiene in between residents, before applying gloves, and after removing gloves. ULP-H On November 5, 2024, at 10:08 a.m., the surveyor observed ULP-H complete scheduled morning medication administration for R9. ULP-H donned gloves, applied topical medications for R9, doffed gloves, and assisted R9 with dressing. The surveyor did not observe ULP-H complete hand hygiene before or after donning/doffing gloves. On November 5, 2024, at 10:26 a.m., ULP-H stated ULP-H typically completed hand hygiene before and after removing gloves, however, ULP-H forgot ULP-H's hand sanitizer in ULP-H's bag this morning. On November 5, 2024, at 12:18 p.m., CNS-B stated ULPs were trained to complete hand hygiene before and after medication administration along with before and after the use of gloves. CNS-B further stated CNS-B ULPs were provided training and competency of handwashing at hire along with annual training. CNS-B stated CNS-B completed infection control audits, which included hand hygiene, every six months. The licensee's 8.17 Hand Washing policy dated September 20, 2021, indicated hand washing shall be completed before and after administering medications to a resident, after touching a garbage, before putting on gloves, and after	0 510		

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0 510	Continued From page 7 removing gloves. The licensee's 8.15 Gloves policy dated September 20, 2021, indicated to wash hands before and after applying/removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 580		

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0 580	Continued From page 8 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: During the entrance conference on November 4, 2024, at 11:18 a.m., licensed assisted living director (LALD)-A stated the licensee had a quality management program based off current needs of the facility and areas of improvement identified by the director. On November 4, 2024, at 12:51 p.m., LALD-A provided Quality Management Notes dated June 5, 2023, July 20, 2023, and August 3, 2023, respectively. LALD-A stated LALD-A was unable to locate any additional documentation of quality management meetings in the past year and LALD-A had just begun serving as the LALD for the licensee. On November 5, 2024, at 9:51 a.m., LALD-D stated LALD-D was unable to locate any additional documentation for quality management after August 2023. The licensee's 2.30 Quality Management policy dated August 1, 2021, indicated the licensee would have at least one documented quality improvement project in place at all times, and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 580		

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0 580	Continued From page 9 (21) days	0 580		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that 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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-G). 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	0 660		

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0 660	Continued From page 10 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment was completed on July 19, 2024, and the facility was determined to be a low risk level. ULP-G was hired on September 9, 2024, to provide direct care services to residents at the assisted living facility. On November 5, 2024, at 6:42 a.m., the surveyor observed ULP-G provide scheduled morning medication administration for R6. ULP-G's record lacked a baseline TB screening and evidence of a two-step TST or TB screening blood test. On November 6, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee was unable to locate ULP-G's TB screening and TB screening blood test. CNS-B further stated all employees were supposed to complete a TB screening form and a TB screening blood test upon hire. The licensee's 8.07 Tuberculosis and Staff Screening policy dated June 17, 2022, indicated new personnel, shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (healthcare workers), shall have a two-step Mantoux or blood test, and no team member shall be permitted to begin work where the work involves sharing the air space with home	0 660		

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RIVERSIDE ASSISTED LIVING	885 MEADOWVIEW CIRCLE NORTH PILLAGER, MN 56473

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0 660	Continued From page 11 care clients until the negative results of the first Mantoux are read and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 12 Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors 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: The licensees EPP dated May 29, 2024, included a blank 4.97 Team Training, Exercise and Evaluation Form policy dated June 15, 2023, however, the EPP lacked documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On November 5, 2024, at 12:13 p.m., licensed assisted living director (LALD)-D stated the licensee should have completed EPP exercises twice per year and LALD-D would have clinical nurse supervisor (CNS)-B provide documentation of the exercises. As of survey exit, the surveyor never received documentation of EPP exercises the licensee had completed.	0 680		

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0 680	Continued From page 13 The licensee's 4.95 Annual Review Checklist dated May 29, 2024, indicated plans, policies and procedures are tested at least annually in one or more exercises that are evaluated and result in corrective actions for plan improvement. In addition, Staff Training and After Action Report was left blank on the Annual Review Checklist. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of 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	0 800		

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0 800	Continued From page 14 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 November 5, 2024, at 9:30 a.m., the surveyor toured the facility with maintenance worker (MW)-E. During the tour, the surveyor observed the following: 1. The emergency light in the corridor near resident room 107 did not work when tested by MW-E. Emergency lights shall be maintained to ensure proper operation during emergencies. 2. Boxes were stored in front of the electrical panel in the storage room. These boxes also prevented the door from fully opening. Electrical panels must be readily accessible and maintained unobstructed. 3. The labeled 20 minute fire door for the kitchen was propped open with a kick-down door stop. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. 4. An extension cord was plugged into a multiplug adapter in resident room 111. An extension cord was used to supply power in resident room 119. Improper use of extension cords creates a fire hazard. During the facility tour interview on November 5, 2024, MW-E verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 15	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 record review and interview, the	0 810		

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0 810	Continued From page 16 licensee failed to develop a fire safety and evacuation plan with the required content, and provide 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). The findings include: On November 5, 2024, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to include room numbers identifying resident rooms on the floor plan included with the Fire and Evacuation Plan 4.71 dated June 18, 2024. Resident room numbers are required to be included on the FSEP floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The Fire and Evacuation Plan 4.71 dated June 18, 2024, was not developed relative to the facility's building layout and life safety systems. The plan referenced smoke compartments but these areas were not identified in the plan.	0 810		

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0 810	Continued From page 17 The Fire and Evacuation Plan 4.71 dated June 18, 2024, included standard resident evacuation procedures such as swing carry, extremity carry, blanket drag, and hip carry, but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including unique or unusual resident needs evident by a lack of these procedures in the plan. This plan directed employees to the med room to access the ICE binder with resident evacuation acuity level and emergency evacuation plan reports. These reports were not included with the readily available copy of the FSEP. During an interview on November 5, 2024, at 11:45 a.m., LALD-D verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. One record for an employee training session on the fire safety and evacuation plan, dated May 2024, was provided, but the names of the employees who attended were not recorded. Additional training records were requested by the surveyor, but none were provided by the LALD-D. During an interview on November 5, 2024, at 11:45 a.m., LALD-D explained no additional records were available to support employee training on the FSEP. LALD-D stated if training records were located, these would be emailed to the surveyor by the end of the day. No further information was received. LALD-D further explained new hire employees were trained on emergency preparedness using a third-party online training provider and verfiied FSEP training had not been	0 810		

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0 810	Continued From page 18 completed. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. Training records were requested by the surveyor, but none were provided by the LALD-D. During an interview on November 5, 2024, at 11:45 a.m., LALD-D explained residents were trained upon admission and during fire drills. LALD-D stated records were not available to support resident training on fire safety and evacuation. LALD-D stated if training records were located, these would be emailed to the surveyor by the end of the day. No further information was received. 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 evident by fire drill reports lacking the required frequency and documentation. Three fire drills were conducted in 2024, dated February 6th, May 22nd, and September 2nd. On the drill form for February 6, 2024, the last names of the employees who participated were not recorded. No 2023 drill records were provided. During an interview on November 5, 2024, at 11:45 a.m., LALD-D verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 19 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for two of eight employees (maintenance worker (MW)-E, cook (C)-F). This had the potential to affect all residents living within 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). The findings include:	01290		

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01290	Continued From page 20 This resulted in an immediate correction order on November 5, 2024. On November 5, 2024, at 11:07 a.m., licensed assisted living director (LALD)-A stated the licensee, including both LALD-A and LALD-D, were aware of required contents in an employee record. MW-E MW-E was hired on November 7, 2018, and had begun to provide to maintenance work at the assisted living facility on August 1, 2021. On November 4, 2024, at 12:21 p.m., the surveyor observed MW-E complete maintenance work in the licensee's laundry room. MW-E was not under direct supervision. MW-E's record contained a cleared COVID-19 background study notice issued by the Minnesota Department of Human Services dated September 13, 2021, however, the COVID-19 background study expired December 31, 2022. MW-E's employee record lacked a current cleared background study. C-F C-F was hired on August 8, 2014, and had begun to cook for residents at the assisted living facility on August 1, 2021. ON November 5, 2024, at 5:47 a.m., the surveyor observed C-F in the resident dining room and kitchen area. C-F was not under direct supervision. C-F's record contained a cleared COVID-19 background study notice issues by the Minnesota	01290		

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01290	Continued From page 21 Department of Human Services dated September 2, 2021, however, the COVID-19 background study expired December 31, 2022. C-F's employee record lacked a current cleared background study. On November 5, 2024, at 11:09 a.m. through 11:29 a.m., the surveyor reviewed the NETStudy 2.0 website and rosters with LALD-D. LALD-D stated MW-E and C-F were employees of the facility. LALD-D stated MW-E worked independently without supervision, and C-F had direct supervision Monday through Friday from the LALD at 9:00 a.m. through 5:00 p.m. each day. LALD-D stated the licensee's NETStudy roster showed MW-E and C-F's background studies as Eligible-Covid-19 Expired. LALD-D completed a search for MW-E and C-F on the NETStudy 2.0 website and the results showed the original Covid-19 expired background studies with no additional background studies completed after the licensee Covid-19 background study expired. LALD-D further stated LALD-D would not disagree the licensee would not be notified if MW-E and C-F would be ineligible to work at the assisted living. The licensee's 3.38 Background Checks policy dated August 2, 2021, indicated [licensee name] will conduct a Minnesota Department of Human Services Background Study on all team members and volunteers of [licensee name]. No team member may have independent direct contact with any tenants or clients (residents) until acceptable result of the background study have been received. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July	01290		

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01290	Continued From page 22 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee provided actions to mitigate the immediacy of correction order 1290 to surveyor supervisor on November 6, 2024, at 8:51 a.m., however, non-compliance remains at a scope and level of three, widespread (I).	01290		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same	01350		

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01350	Continued From page 23 requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employee (registered nurse (RN)-I). 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 November 5, 2024, at 11:07 a.m., licensed assisted living director (LALD)-A stated the licensee, including both LALD-A and LALD-D, were aware of required contents in an employee record. RN-I was hired May 23, 2024, through a contracted agency, to provide on call RN access for staff and residents at the facility. RN-I's employee record lacked the following topics required for orientation to assisted living training: -an overview of the assisted living chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01350		

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01350	Continued From page 24 -the principles of person-centered planning and service delivery and how they apply to director 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 will be providing and the facility's category of licensure. On November 6, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided all trainings in RN-I's employee file and CNS-B would assume all contracted RNs would have received the same training upon hire through the contract agency. The licensee's 10.01 Orientation of Personnel and Content policy dated August 1, 2021, indicated all personnel providing and supervising direct services must complete an orientation to Assist Living [sic] facility licensing requirements and regulations before providing assisted living services to residents. The orientation to assisted living included all above noted topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		

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	27489	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 25	01730		
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 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.	01730		

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01730	Continued From page 26 (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 two residents (R9). 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: During the entrance conference on November 4, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R9's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), major depression disorder, congestive heart failure (CHF), and gastroesophageal reflux disease (GERD- acid reflux). R9's service plan dated August 20, 2024, indicated services included medication administration 13 times per day.	01730		

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01730	Continued From page 27 R9's prescriber orders dated April 19, 2024, included the following orders: -mometasone furoate (for skin irritation) 0.1% cream apply topically to affected areas twice daily -Voltaren (for arthritis) 1% gel apply topically to affected areas four times daily On November 5, 2024, at 10:08 a.m., the surveyor observed unlicensed personnel (ULP)-H remove R9's mometasone furoate cream and Voltaren gel from R9's unlocked bathroom cabinet, applied the medications topically on R9, and returned both medications to R9's unlocked bathroom cabinet. R9's Clinical Update Assessment dated September 27, 2024, indicated under R9's medication management plan all medications were stored in locked medication cart and/or central storage, and medication self-administration was not applicable. R9's individualized medication management plan did not match current medication storage for R9. On November 5, 2024, at 10:24 a.m., ULP-H stated R9 had kept topical medications in R9's bathroom cabinet after R9 was assessed to store the medications in R9's room. On November 5, 2024, at 10:45 a.m., ULP-G stated residents could store medications in a resident room if it was listed on a resident's EMAR (electronic medication administration record). On November 6, 2024, at 1:42 p.m., CNS-B stated R9's medication management plan was not updated to reflect R9 could store topical medications in R9's room. CNS-B further stated	01730		

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01730	Continued From page 28 all medications needed to be stored in a secured (locked) location. The licensee's 12.05 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that included a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. The medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. This had the potential to affect all residents receiving refrigerated medications.	01880		

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01880	Continued From page 29 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 November 4, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On November 5, 2024, at 1:59 p.m., licensed practical nurse (LPN)-C stated the current temperature of the locked medication refrigerator located in the medication room was 36 degrees Fahrenheit (F), staff checked the refrigerator temperature every shift, and the refrigerator contained the following medications: -eight unopened Lantus 100 units/milliliter (mL) insulin pens for R2 -one unopened Dupixent 300 milligrams (mg)/2 mL pen for R10 The licensee's Medication Refrigerator Temperature Log dated October 2024, and November 2024, respectively, indicated the medication refrigerator temperature was checked on every shift (three times daily) and Frig (refrigerator) must be between 36-46 degrees. If temperature is outside this range, please adjust dial as needed and recheck temp (temperature) in 1 (one) hour. Notify ONCALL [sic] if outside these temperature ranges. From October 1, 2024, through November 3, 2024, the Medication Refrigerator Temperature Logs indicated the	01880		

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01880	Continued From page 30 following: -72 of 102 opportunities the medication refrigerator temperature was recorded; and -34 out of 72 opportunities the medication refrigerator temperature was out of range and the medication refrigerator temperature was recorded less than 36 degrees F. On November 6, 2024, at 1:39 p.m., CNS-B stated if the medication refrigerator temperature was not within 36 degrees F to 46 degrees F, ULPs were supposed to contact the licensed assisted living director (LALD), follow instructions on how to adjust the refrigerator temperature, and complete a follow up of the temperature after adjusting the temperature of the medication refrigerator. On November 6, 2024, at 2:29 p.m., CNS-B stated CNS-B was still looking for follow up documentation regarding adjusts made to the medication refrigerator when the medication refrigerator temperature was out of range (36 degrees F to 46 degrees F), however, no additional documentation was provided to the surveyor. The manufacturer's instructions for Lantus dated May 2019, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Dupixent dated October 2018, indicated to store unopened Dupixent in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Dupixent to freeze. The licensee's 12.17 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's	01880		

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01880	Continued From page 31 recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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. (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 to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge.	01910		

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01910	Continued From page 32 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: During the entrance conference on November 4, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. The licensee's Discharged Resident/Client Roster dated November 4, 2024, indicated R1 was admitted to the facility on September 23, 2021, and discharged on September 26, 2024. R1's diagnoses included diabetes, hypertension (HTN- high blood pressure), and osteoporosis (weak and brittle bones). R1's service plan dated September 19, 2024, indicated R1 received medication administration six times per day. R1's Medication Administration Record (MAR) dated November 2023, indicated R1 received the following medications: -diclofenac sodium (for arthritis) 1% apply 4 (four) grams topically to affected joints four times daily -amlodipine (for HTN) 5 milligrams (mg) daily -Januvia (for diabetes) 50 mg daily -menthol-zinc oxide ointment (for skin irritation) topically to affected area three times daily	01910		

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01910	Continued From page 33 -pantoprazole (for acid reflux) 40 mg daily -paroxetine (antidepressant) 20 mg daily -Basaglar (for diabetes) 12 units daily -donepezil (for dementia) 5 mg daily -memantine HCL (for dementia) 5 mg daily R1's prescriber orders dated August 12, 2024, included the above noted medications. R1's Discharge/Transfer Summary dated September 26, 2024, indicated R1 was deceased on September 22, 2024, under the care of hospice. R1's Medication Disposition-Resident dated September 25, 2024, listed the above noted medications, however, lacked memantine, donepezil, and pantoprazole's prescription number. On November 6, 2024, at 1:36 p.m., CNS-B stated R1's above noted medications lacked the prescription number and the prescription numbers must have been missed being entered into R1's electronic medical record. CNS-B further stated the licensee was aware prescription numbers as applicable were required for all medication dispositions. The licensee's 12.39 Medication Disposal policy dated August 1, 2021, indicated for unused prescription drugs (medications) upon disposition the facility must document in the resident's record the disposition of the medication including the prescription number as applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of one resident (R9). 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 November 5, 2024, at 10:06 a.m., the surveyor observed unlicensed personnel (ULP)-H provide scheduled morning cares to R9. During the observation in R9's room, the surveyor observed six tall oxygen cylinders secured in a cardboard rack (stand) and one unsecured tall oxygen cylinder placed next to the cardboard rack. On November 5, 2024, at 10:23 a.m., ULP-H stated the unsecured oxygen cylinder in R9's	02310		

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02310	Continued From page 35 room may have been empty and kept out of the cardboard rack for staff to know the oxygen tank was empty. On November 5, 2024, at 10:43 a.m., ULP-G stated R9's oxygen tanks were supposed to be stored in the cardboard stand located in R9's room. On November 5, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated all oxygen tanks should be stored upright in a carrier (stand) provided by the oxygen supply company. The licensee's 12.69 Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained	02320		

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02320	Continued From page 36 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-G). 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: During the entrance conference on November 4, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On November 5, 2024, at 8:30 a.m. until 8:44 a.m., the surveyor observed ULP-G provide scheduled morning medication administration to R2, which included Miralax 17 grams mixed with 8 (eight) ounces of water and potassium chloride 10% -15 milliliters (mL) mixed with 4 (four) ounces of water. ULP-G brought R2's scheduled morning medication to R2's room, observed R2 swallow oral pills, applied R2's topical ointment, left R2's Miralax and potassium chloride on a	02320		

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02320	Continued From page 37 stand for R2 to self-administer, returned to the computer, and documented on R2's electronic medication administration record (EMAR) all R2's scheduled morning medications were administered. The surveyor did not observe ULP-G administer R2's Miralax or potassium chloride. On November 5, 2024, at 10:43 a.m., ULP-G stated R2 was still "working" on drinking R2's Miralax and potassium chloride and ULP-G would return to R2's room later to ensure R2 administered Miralax and potassium chloride. ULP-G further stated R2's EMAR did not indicate self-administration of oral medications. On November 6, 2024, at 1:49 p.m., CNS-B stated ULPs were trained to observe residents taking medications, unless the EMAR indicated the resident could self-administer a medication, and after the observation of the medications being taken the ULPs should return to the EMAR to document the medications were administered. The licensee's 12.11 Medication Management: Administration and Setup policy dated August 1, 2021, indicated documentation of a medication administration will be completed immediately after that task (medication administration) has been performed. The licensee's 12.05 Medication Management Individualized Plan policy dated August 1, 2021, indicated the individualized medication management record for each resident based on the resident's assessment would include documentation of specific resident instructions relating to the administration of medications. No further information was provided.	02320		

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02320	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Department of Health

705 5th Street NW SuiteA
Bemidji, MN
218-308-2100

Type: Follow-Up
Date: *11/15/24*
Time: 14:31:44
Report: 1040241136

Food and Beverage Establishment Inspection Report

Location:
Riverside Assisted Living of P
885 Meadowview Circle
Pillager, MN56473
Cass County, 11

Establishment Info:
ID #: 0024941
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Riverside Assisted Living, Inc

Phone #: 2187464400
ID #: 32072

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 previously issued on 11/06/24 have NOT been corrected.

2-100 Supervision

2-102.11DEFG ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.
AT TIME OF INSPECTION CFPM DID NOT KNOW COOLING TEMPERATURES
Issued on: 11/06/24 *Comply By: 11/13/24*

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
AT TIME OF INSPECTION NO THIN TIP THERMOMETERS AVAILABLE
Issued on: 11/06/24 *Comply By: 11/13/24*

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
AT TIME OF INSPECTION NO QUATERNARY AMMONIA TEST STRIPS AVAILABLE FOR SANITIZER SPRAY BOTTLE
Issued on: 11/06/24 *Comply By: 11/13/24*

Type: Follow-Up
Date: *11/15/24*
Time: 14:31:44
Report: 1040241136
Riverside Assisted Living of P

Food and Beverage Establishment Inspection Report

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
OBSERVED GREEN RESIDUE BUILDUP ONCE AGAIN IN ICE MACHINE
Comply By: 11/15/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: WAREWASHING MACHINE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	4	0

DISCUSSED FURTHER METHODS TO PREVENT RESIDUE BUILD UP IN ICE MACHINE

STAFF STATED THAT THE THIN TIP THERMOMETER AND QUATERNARY AMMONIA TEST STRIPS WERE ORDERED, BUT HAD NOT ARRIVED YET

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

I acknowledge receipt of the Department of Health inspection report number 1040241136 of 11/15/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: *Vania Jeh*
Vania Jeh
Public Health Sanitarian
705 5th Street NW, Suite A
218-308-2124
vania.jeh@state.mn.us

Department of Health

705 5th Street NW SuiteA
Bemidji, MN
218-308-2100

Type: Full
Date: *11/06/24*
Time: 13:18:39
Report: 1040241135

Food and Beverage Establishment Inspection Report

Location:
Riverside Assisted Living of P
885 Meadowview Circle
Pillager, MN56473
Cass County, 11

Establishment Info:
ID #: 0024941
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Riverside Assisted Living, Inc

Phone #: 2187464400
ID #: 32072

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.

2-300 Personal Cleanliness

2-301.14B-G ***** Priority 1 *****

MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.

OBSERVED FAILURE TO WASH HANDS BEFORE DONNING GLOVES TO SERVE FOOD

Comply By: 11/06/24

2-100 Supervision

2-102.11DEFGHI ***** Priority 2 *****

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

AT TIME OF INSPECTION CFPM DID NOT KNOW COOLING TEMPERATURES

Comply By: 11/13/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

AT TIME OF INSPECTION NO THIN TIP THERMOMETERS AVAILABLE

Comply By: 11/13/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

AT TIME OF INSPECTION NO QUATERNARY AMMONIA TEST STRIPS AVAILABLE FOR SANITIZER SPRAY BOTTLE

Comply By: 11/13/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED GREEN RESIDUE IN ICE MACHINE, IMMEDIATELY CLEANED AND SANITIZED BY MAINTENANCE

Corrected on Site

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED NON FOOD-GRADE PLASTICS BEING USED TO HOLD FOODS

Comply By: 11/13/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

OBSERVED CARDBOARD BEING USED TO HOLD ITEMS ON SHELVES IN DRY STORAGE

Comply By: 11/13/24

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.

OBSERVED DOMESTIC COOLER BEING USED TO HOLD MILK GALLONS

Type: Full
Date: *11/06/24*
Time: 13:18:39
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Riverside Assisted Living of P

Food and Beverage Establishment Inspection Report

Comply By: 11/13/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

AT TIME OF INSPECTION WAREWASHING MACHINE NOT DISPENSING CHLORINE

Comply By: 11/13/24

Surface and Equipment Sanitizers

Chlorine: = 0PPM at Degrees Fahrenheit
Location: WAREWASHING MACHINE
Violation Issued: Yes

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

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 208F Degrees Fahrenheit - Location: CABBAGE DINNER FROM OVEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0F Degrees Fahrenheit - Location: KITCHEN ARCTIC AIR FREEZER, AMBIENT TEMPERATURE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40F Degrees Fahrenheit - Location: KITCHEN ICECASA COOLER, MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39F Degrees Fahrenheit - Location: KITCHEN ICECASA COOLER, SOUP
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0F Degrees Fahrenheit - Location: DRY STORAGE FREEZER, AMBIENT TEMPERATURE

Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	4	4

ATTACHED COOLING FACT SHEET AND EMPLOYEE ILLNESS LOG TO EMAIL SENT TO HRD

Type: Full
Date: *11/06/24*
Time: 13:18:39
Report: 1040241135
Riverside Assisted Living of P

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Department of Health inspection report number 1040241135 of 11/06/24.

Certified Food Protection Manager: CHERYL L. MILLER

Certification Number: 36570 Expires: 02/28/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Vania Jeh

Vania Jeh
Public Health Sanitarian
705 5th Street NW, Suite A
218-308-2124
vania.jeh@state.mn.us