Electronically Delivered

January 3, 2023

Licensee
River Grand Senior Living
355 River Road
Grand Rapids, MN 55744

RE: Project Number(s) SL28963015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28963	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GRAND SENIOR LIVING	355 RIVER ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#28963015 On, December 5, 2022, through December 7, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 71 residents, 68 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 5, 2022, at 10:31a.m., LALD-A identified herself as the LALD for the facility. LALD-A obtained an assisted living director license on October 20, 2021. On December 5, 2022, at 10:33 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed with LALD-A. The BELTSS website indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On December 5, 2022, immediately after BELTSS website was reviewed with LALD-A, LALD-A confirmed she was not listed as the Director of Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 3 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 included document titled, Food and Beverage Establishment Inspection Report dated December 5, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individual abuse	0 630		

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0 630	Continued From page 4 prevention plans (IAPP) were developed to include the required content for three of five residents (R5, R6, R10). 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: R5 R5's diagnoses included hypertension. R5's rental agreement was signed July 19, 2021. R5's IAPP dated August 29, 2022, identified areas of vulnerability with interventions; however, lacked a review of R5's risk of abusing other vulnerable adults, and the potential risk of self-abuse. R6 R6's diagnoses included dementia, diabetes type two, chronic obstructive pulmonary disease (COPD), lower extremity edema, pain, hypertension, and atrial fibrillation (irregular heartbeat). R6's service plan dated November 8, 2022, indicated R6 received medication administration, assistance with bathing, toileting, compression stocking, housekeeping, and laundry.	0 630		

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0 630	Continued From page 5 R6's IAPP dated October 24, 2022, identified areas of vulnerability with interventions; however, lacked a review of R6's risk of abusing other vulnerable adults, and the potential risk of self-abuse. R10 R10's diagnoses included dementia, hypertension, COPD, asthma, osteoarthritis, congestive heart failure, and depression. R10's service plan dated September 23, 2022, indicated R10 received medication administration, assistance with bathing, knee brace, housekeeping, and laundry. R10's IAPP dated November 2, 2022, identified areas of vulnerability with interventions; however, lacked a review of R10's risk of abusing other vulnerable adults, and the potential risk of self-abuse. On December 7, 2022, at 12:34 p.m., director of nursing (DON)-B and registered nurse (RN)-C reviewed R5, R6 and R10's IAPP with surveyor and confirmed the IAPP's did not include assessments for the resident's risk of abusing others or risk of self-abuse. The licensee's Vulnerable Adult Reporting and Investigation policy dated July 2022, indicated the facility would develop and implement and individual abuse prevention plan for each vulnerable adult that lives in the facility regardless of services needs. The plan must contain: -an individual review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable adults; and	0 630		

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0 630	Continued From page 6 -statements of the specific measures to be taken to minimize the risk of abuse to that person, and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=D	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas in the secured memory care unit to include posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect 12 residents, staff and visitors.	0 640		

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0 640	Continued From page 7 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 a facility tour of the secured dementia unit on December 5, 2022, at 11:37 a.m., with licensed assisted living director (LALD)-A, the 911 emergency number was found posted in the kitchen area of the memory unit, above the stove. LALD-A stated the kitchen area in the memory care unit was not a common area. LALD-A stated the facility did not have "a phone" or phones for residents use, adding residents could use the i-phones staff carried. The staff i-phones did not have the 911 number visible. On December 6, 2022, at 4:40 p.m., LALD-A confirmed the memory care unit did not have the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to prominently post a written emergency preparedness plan. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 11:35 a.m., a facility tour was conducted with licensed assisted living director (LALD)-A. There was no observed signage posted or information regarding the licensee's emergency preparedness plan (EPP) in the common areas of the facility. On December 5, 2022, at approximately 12:00 p.m., the surveyor observed LALD-A go into the kitchen area of the locked memory unit. LALD-A opened a cabinet above the stove/range hood and produced a red emergency plan binder. LALD-A stated the kitchen was not a "common area." On December 2022, at 12:37 p.m., in the main entry of the open common's area of the assisted living the surveyor observed LALD-A go through a closed door that led to an area behind front desk and office areas. LALD-A returned with an emergency preparedness plan binder. LALD-A stated the door that allowed access behind the front desk area was never locked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 10 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 the potential to affect a large portion or all residents).	0 780		

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0 780	Continued From page 11 The findings include: On December 6, 2022, between 11:00AM and 3:30PM, survey staff toured the facility with Director of Maintenance Director-I and LALD-A, during the facility tour, survey staff observed smoke barrior walls to be in disrepair and/or penetrations were visible above ceiling tiles. Director of Maintenance Director-I and LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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	28963	A. BUILDING: _____ B. WING _____	12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER GRAND SENIOR LIVING	355 RIVER ROAD GRAND RAPIDS, MN 55744

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0 800	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On December 6, 2022, between 11:00AM and 3:30PM, survey staff toured the facility with Director of Maintenance Director-I and LALD-A, during the facility tour, survey staff observed high piled storage throughout the facility, mainly in storage closets on first and second floors. Director of Maintenance Director-I and LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 13 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 include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation 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 December 5, 2022, at 10:25 a.m., the surveyor asked for a copy of the licensee's assisted living contract and licensed assisted living director (LALD)-A confirmed, The Resident Agreement was used for all residents. The Resident Agreement Summary and Contract Information was provided and later reviewed by the surveyor. The assisted living contract included three clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 9, section 18, Personal Property. The resident agrees that Provider is not responsible for any loss or damage to resident's personal property due to any reason or cause, including theft, other than provider's own negligence. Resident further agrees that provider is not responsible for damage to resident's personal property due to fire, water, tornado, or other acts of nature and events beyond provider's control.	0 970		

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0 970	Continued From page 14 Page 12, section 23. Indemnification indicated as an occupant of the community, resident assumes the risk for resident's own safety. Resident will indemnify and hold harmless provider, its employees, officers, managers, members, agents and affiliates from and against any and all claims, actions, damages and liability and expenses in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act of omission of resident. Page 13, section 25. Liability indicated provider is not liable to resident for any injury, death or property damage occurring in the apartment or on provider's premises unless such injury, death or property damage occurs as the result of provider's own negligent acts or omission, or those of its employees, officers, manager, members, agent, or affiliates. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrences in the apartment or on provider's premises. On December 6, 2022, at 4:54 p.m., LALD-A reviewed the Resident Agreement Summary and Contract Information containing the sections noted above and stated the Resident Agreement was reviewed by an attorney and would have to look further into the language used in the Resident Agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of venue provision. This had the potential to affect all residents. This practice resulted in a level one violation, 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 December 5, 2022, at 10:25 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The Resident Agreement Summary and Contract Information was provided and later reviewed by the surveyor. The Resident Agreement used for all residents included an arbitration section. In section G. under Location of Binding Arbitration, indicated	0 980		

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0 980	Continued From page 16 the Binding Arbitration would be conducted at a site selected by Landlord, which shall be at Landlords' building or a site within a reasonable distance of Landlord's Building. On December 6, 2022, at 4:54 p.m., licensed assisted living director (LALD)-A reviewed the Arbitration Agreement in the Resident Agreement Summary and Contract Information and acknowledged the above noted section was making a provision on where the arbitration would be held and stated the Resident Agreement was reviewed by an Attorney and would have to look further into the language used in the Arbitration Agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		
01060 SS=D	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; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 17 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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of four 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	01060		

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01060	Continued From page 18 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: R9's diagnoses included diabetes, right hip fracture, neck fracture, cervical fracture, atrial fibrillation, anemia and dementia. R9's Service Plan dated November 14, 2022, included medication administration ten times daily, sensor alarms daily, compression stockings (TEDs), daily blood pressure monitoring, external catheter management, behavior management, assistance with toileting, grooming, feeding, and vital signs monitoring. R9's Resident Notes dated November 1, 2022, included R9 was taken to (name of hospital) emergency room via ambulance to be evaluated. R9's Resident Notes dated November 7, 2022, included R9 returned to facility at 5:00 p.m., after a hospital stay. R9 left the facility on November 1, 2022, and returned on November 7, 2022. R9 was out of the facility over four days. R9's record lacked a written notice that contained, at a minimum: - reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 19 expected to return to the facility, or a statement that a return date is not currently known; - a statement if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144.54. The facility must provide contact information for the agency to which the resident may submit an appeal; - the notice must be delivered as soon as practicable to: - the resident, legal representative, and designated representative; - for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident has been relocated. On December 6, 2022, at 3:09 p.m., director of nursing (DON)-B stated the Ombudsman was not contacted as required for R9. DON-D added they [facility staff] recently received training on this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to	01420		

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01420	Continued From page 20 demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN) provided training and competency evaluations for two of two unlicensed personnel (ULP)-E, ULP-F on pressure alarms. In addition, the licensee failed to ensure the RN provided training and competency evaluations for one of one staff on Purewick (external female catheter) ULP-F. 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: PRESSURE ALARM ULP-E was hired June 28, 2010, under the former home care license and began providing assisted living with dementia care services on August 1, 2021.	01420		

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01420	Continued From page 21 ULP-F was hired July 5, 2022, to provide direct care and services to residents at the assisted living with dementia care facility. On December 6, 2022, at approximately 10:40 a.m., the surveyor observed ULP-E and ULP-F assist R9 into a sitting position on the side of R9's bed. ULP-E reached down and shut off the pressure pad which was on R9's bed. ULP-E and ULP-F transferred R9 into a Broda wheelchair. ULP-F reached down and turned on the pressure pad alarm that was on R9's wheelchair. ULP-E's record lacked documentation to indicate ULP-E had received training and demonstrated competency for pressure alarms. ULP-F's record lacked documentation to indicate ULP-F had received training and demonstrated competency for pressure alarms. On December 6, 2022, at approximately 3:05 p.m., director of nursing (DON)-B stated ULP-E and ULP-F's records did not have evidence of training and demonstration of competency for pressure alarms. DON-B stated none of the ULP's the the facility had demonstrated competency on pressure alarms. PUREWICK SYSTEM On December 6, 2022, at 9:14 a.m., the surveyor observed ULP-F go into R9's room. R9 was lying in bed and there was a canister with a hose attached to it on a stand next to R9's bed. ULP-F stated the first time she had seen R9's Purewick system was on Sunday night. ULP-F added another ULP who was working on the unit showed ULP-F how to put "it" (Purewick system)	01420		

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01420	Continued From page 22 on. On December 6, 2022, at approximately 10:35 a.m., the surveyor observed ULP-E say to ULP-F "I'll show you how to get it (Purewick) off. You just pull it out." ULP-E stated she would show ULP-F how to clean the Purewick system after they had completed R9's cares. ULP-F's record lacked documentation to indicate ULP-F had received training and demonstrated competency for Purewick system. On December 6, 2022, at 3:00 p.m., DON-B confirmed ULP-F had not been trained or demonstrated competency on the Purewick system. The licensee's Delegation of Nursing Tasks, Treatment or Therapy Tasks policy reviewed November 2022, indicated the RN may delegate nursing services, or an authorized Licensed Health Professional (LHP) may delegate treatments or assisting therapy tasks, to unlicensed personnel that: -have successfully completed the training required for unlicensed personnel under MN Statutes 144G.61 subd. 2 (a) *1-15) including (b) (1-7) for staff providing assisted living services; -have been trained in the services to be provided; and -have demonstrated to the RN or the LHP the ability to competently follow the procedures for the resident and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include the use of a neck collar for one of four 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) and was issued at an	01620		

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01620	Continued From page 24 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: R9 R9's diagnoses included diabetes, right hip fracture, neck fracture, cervical fracture, atrial fibrillation, anemia and dementia. R9's Service Plan dated November 14, 2022, included medication administration ten times daily, sensor alarms daily, compression stockings (TEDs), assist with toileting, transfers, dressing, grooming, and feeding, daily blood pressure monitoring, external catheter management, behavior management, and vital signs monitoring. On December 6, 2022, at 10:28 a.m., the surveyor observed R9 lying in bed wearing a neck collar. Unlicensed personnel (ULP)- E and ULP-F washed R9's body while R9 was in bed, applied TEDs, dressed R9 in pants and shoes, and assisted R9 into a sitting position. R9's nurses note dated October 31, 2022, included, "will need to wear a cervical collar and will need to follow up with neuro in four weeks." R9's nurses note dated November 30, 2022, stated, "continue to wear neck brace at all times, ok to take off to shower then put back scheduled CT scan for January 3rd." R9's November 14, 2022, assessment included R9's neck collar regarding eating, and failed to include R9's neck collar anywhere else in the	01620		

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01620	Continued From page 25 assessment. On December 6, 2022, at 4:58 p.m., director of nursing (DON)-B confirmed R9's assessment failed to address the neck collar fully. DON-B stated her expectation was R9's assessment would include the neck collar, for "skin if nothing else". DON-B added there had been some skin breakdown. DON-B stated the neck collar would impact R9's dressing also. The licensee's Initial and On-Going Nursing Assessment of Assisted Living Residents revised October 2022, indicated ongoing reassessments and monitoring would be conducted by the RN as needed based on the needs of the resident but could not exceed 90 days from the date of the last assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700		

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01700	Continued From page 26	01700		

resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment to include self-medication administration for one of one resident (R4) who self-administered topical medications.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 December 5, 2022, at 10:31 a.m., licensed assisted living

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01700	Continued From page 27 director (LALD)-A, director or nursing (DON)-B, and RN-C indicated the licensee provided medication management services. R4's diagnoses included macular degeneration, dermatitis (common skin irritation), hypertension, diabetes, hypothyroidism, insomnia, spinal stenosis (narrowing of the spinal canal) and depression. R4's Service Plan dated July 1, 2022, indicated R4 received medication administration. R4's Individualized Medication Management Plan dated October 11, 2022, indicated R4 administered topical ointments including calmoseptine (treat and prevent minor skin irritations), nystatin powder (fungus infections of the skin), and Sarna lotion (itchy, dry skin). R4's prescriber orders dated November 9, 2022, indicated R4 had orders to self-administer calmoseptine topical ointment, nystatin powder and Sarna lotion. R4's Master Care Plan dated November 11, 2022, indicated R4 required assistance with medication administration. R4's 90-day assessment dated October 11, 2022, indicated R4 required assistance with medications including oral (by mouth), eye drops and topical (applied to the skin) medication. R4's assessment lacked a self-medication assessment to include R4 was competent to administer her own topical medications. On December 7, 2022, at 12:34 p.m., RN-C stated R4 had been assessed by the nurse to self-administer creams and ointments and had an	01700		

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01700	Continued From page 28 order from R4's prescriber. RN-C confirmed R4's 90-day assessment dated October 11, 2022, did not indicate R4 was able to self-administer her topical ointments including calmoseptine, Sarna lotion and nystatin powder. The licensee's Development of the Individual Medication Management Plan and Individualized Medication Record policy dated April 2022, indicated based on the comprehensive nursing assessment, the RN would develop an individualized mediation management plan for each resident needs or requests medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01750		

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01750	Continued From page 29 review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of four 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: R9's diagnoses included diabetes, right hip fracture, neck fracture, cervical fracture, atrial fibrillation, history of blood clots, anemia and dementia. R9's Service Plan dated November 14, 2022, included medication administration ten times daily. On December 6, 2022, at 10:28 a.m., the surveyor observed R9 lying in bed wearing a neck collar. Unlicensed personnel (ULP)- E and ULP-F washed R9's body while R9 was in bed, applied TEDs, dressed R9 in pants and shoes, and assisted R9 into a sitting position. R9's medication administration record (MAR) dated December 1, 2022, through December 6, 2022, included: -Advair Diskus (wheezing and shortness of breath) 250 micrograms (mcg)/50 mcg's. Inhale one puff into the lungs two times daily; -Jantoven (blood thinner) 2.5 milligrams (mg)	01750		

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tablet. Tuesday, Thursday, Saturday, Sunday; and
-Jantoven 5 mg tablet Monday, Wednesday, Friday.

R9's MAR lacked written directions to rinse mouth thoroughly with water and to spit after each use of Advair.

R9's MAR lacked written directions to report bruising or bleeding to nursing with Jantoven.

On December 6, 2022, at 4:07 p.m., registered nurse (RN)-C stated the MAR's "come right from pharmacy." RN-C stated her expectation would be for staff to have residents rinse their mouths after Advair use.

On December 6, 2022, at 4:49 p.m., director of nursing (DON)-B stated training for blood thinners was done on Educare (on-line education) upon hire. DON-B confirmed R9's record failed to have specific instructions to monitor or report bleeding/ bruising on MAR or care plan.

The licensee's Administration of Medication by Unlicensed Personnel policy reviewed July 2022, indicated the RN may delegate unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medication if the unlicensed personnel have satisfied the training requirements;
-before performing the procedures, the RN had instructed the unlicensed personnel in the proper methods to administer the medication and the unlicensed personnel have demonstrated the ability to competently follow the procedures;
-the RN has developed written, specific instruction for each resident for administering the

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01750	Continued From page 31 medications; -the RN has communicated with the unlicensed personnel about the individual needs of the resident; and the RN has documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	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 prescribed for two of four residents (R9, R6). In addition, the licensee failed to ensure medication orders were transcribed correctly for one of four resident (R9).	01760		

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01760	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 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: MEDICATION ADMINISTERED AS PRESCRIBED R9 R9's diagnoses included diabetes, right hip fracture, neck fracture, cervical fracture, atrial fibrillation, anemia and dementia. R9's Service Plan dated November 14, 2022, included medication administration ten times daily. R9's prescriber orders dated November 7, 2022, included Senna-S (stool promoter and stool softener) 8.5 milligrams (mg)-50 mg tablet, one tablet by mouth two times per day. R9's medication administration record (MAR) dated December 1, 2022, through December 6, 2022, included Senna-S 50 mg-8.6 mg take one tablet by mouth two times daily, hold as needed for loose stools. R9's December 1, 2022, through December 6, 2022, MAR included Senna-S 50 mg-8.6 mg to be given daily at 10:00 a.m. R9's December 2022	01760		

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01760	Continued From page 33 MAR did not include Senna S to be given two times per day. On December 6, 2022, at 10:28 a.m., the surveyor observed R9 lying in bed wearing a neck collar. Unlicensed personnel (ULP)- E and ULP-F washed R9's body while R9 was in bed, applied TEDs, dressed R9 in pants and shoes, and assisted R9 into a sitting position. On December 7, 2022, at 11:17 a.m., director of nursing (DON)-B stated R9's Senna "it is not on the MAR twice." DON-B confirmed R9's December 2022 MAR was incorrect and Senna was not being administered as ordered. R6 R6's diagnoses included dementia, type two diabetes, chronic obstructive pulmonary disease (COPD), lower extremity edema, pain, hypertension, and atrial fibrillation (irregular heartbeat). R6's service plan dated November 8, 2022, indicated R6 received daily medication administration. R6's prescriber orders dated December 6, 2022, included and order for fluticasone propionate and sametero l100-50 micrograms (mcg)(COPD) inhale one puff by mouth twice a day and rinse mouth after use. R6's November 1, 2022, through November 30, 2022, and December 1, 2022, through December 6, 2022, MAR indicated R6 received fluticasone propionate and salmeterol one puff by mouth twice a day. On December 6, 2022, at approximately 8:17	01760		

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a.m., unlicensed personnel (ULP)-D was observed to conduct a medication pass for R6 which included administration of the fluticasone propionate inhaler. ULP-D administered R6's oral medications, handed the inhaler to R6 and R6 inhaled one puff. R6 handed the inhaler back to ULP-D. ULP-D proceeded to administer R6's scheduled insulin. The surveyor did not observe ULP-D instruct R6 to rinse his mouth out after the administration of the inhaler.

On December 6, 2022, at 8:22 a.m., ULP-D stated she did not have R6 rinse his mouth after the use of the inhaler and verified R6's MAR directed to rinse mouth out following the administration of fluticasone propionate inhaler.

On December 6, 2022, at 2:16 p.m. RN-C stated staff should be following the MAR for directions for medication administrations and should have reminded R6 to rinse his mouth out after the using the inhaler.

The manufacturer's instructions for use of the Wixela Inhub (fluticasone propionate) inhaler, dated August 2022, indicated the resident should rinse their mouth with water after use and spit the water out. Do not swallow the water.

MEDICATION INSTRUCTION

R9's prescriber orders dated November 7, 2022, included Miralax 17 grams by mouth daily.

R9's December 1, 2022, through December 6, 2022, MAR included Miralax (constipation) "mix 17 grams in liquid and take by mouth daily. May adjust for desired affect (sic)."

On December 7, 2022, at 9:21 a.m., DON-B

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01760	Continued From page 35 confirmed the instructions given to staff were incorrect, stating "I would not have put that [may adjusted for desired affect (sic)] on there. I don't know who did." The licensee's Implementation of Medication Prescriptions, treatment and Therapy Orders, reviewed July 2022, indicated the licensed nurse responsible for completing the order must cover all of the steps listed above and check them off as they are done. All orders would be double checked for accuracy by another licensed nurses and signed by both nurses (the nurse that processed the order and the nurse completing the double check). The double check should include checking that dosage was calculated correctly and all information was entered into the orders tab correctly. The licensee's Administration of Medication by Unlicensed Personnel policy reviewed July 2022, indicated the registered nurse had developed written, specific instruction for each resident for administering the medications. The licensee's Administration of Medications by Unlicensed Personnel policy revised July 2022, indicated to instruct resident to rinse mouth and spit after the administration of an inhaler. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 36 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 medication was secured in a locked area for one of four residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On December 6, 2022, at 6:37 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R7 to the bathroom. The surveyor observed the following containers sitting on the counter in R7's room, near kitchen sink, above locked medication drawer: -unopened bottle of arthritis pain medication (acetaminophen/pain), 650 milligrams (mg); -unopened bottle of probiotics 20 billion active cultures (supplement); -unopened bottle of vitamin B complex (supplement); -unopened bottle of vitamin C 500 mg supplement); -unopened bottle of calcium-mag (supplement); and -two unopened bottles of garlic 2000 mg	01880		

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01880	Continued From page 37 (supplement). R7's Service Plan dated October 5, 2022, included medication administration ten times daily. R7's Individualized Medication Management Plan dated November 2, 2022, included: -secure storage of all medications; medications will be locked in medication drawer/cabinet in resident's apartment; and -Self-administration of medications; not applicable. R7's prescriber orders dated September 8, 2022, included acetaminophen ER (extended release) 650 mg, one tablet daily, morning and one tablet daily as needed. On December 7, 2022, at 12:36 p.m., director of nursing (DON)-B stated R7's son brings in over the counter medication (OTC) medications and facility nursing staff has communicated with R7's son multiple times regarding this issue. Licensed assisted living director (LALD)-A and DON-B verified staff should bring OTC medications found in R7's room to nurse's attention. DON-B stated, "if the facility is managing medications, they want to manage all medications." The licensee's Storage of Medications policy reviewed April 2022, indicated the registered nurse may identify the need for secured storage of the medications within the resident's private living space because of the resident's cognitive status, concerns about medication diversion or other concerns. Each resident's apartment has a locked kitchen drawer or cabinet for storage of medications. When secured storage of the medications was necessary, the RN would	01880		

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01880	Continued From page 38 identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for three of four residents (R6, R10, R9). In addition, the licensee failed to ensure time sensitive medications were dated with expiration date for one of four residents (R10). 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	01890		

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01890	Continued From page 39 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ORIGINAL PRESCRIPTION LABELS R6 On December 6, 2022, at 8:17 a.m., unlicensed personnel (ULP)-D was observed to conduct a medication pass for R6, which included administration of the fluticasone propionate 100-50 micrograms (mcg) inhaler (used for wheezing and shortness of breath). R6's inhaler was kept in R6's apartment in a locked drawer. R6's fluticasone propionate inhaler lacked an original prescription label with information regarding the directions for use, medication name, medication dosage resident's name, and the pharmacy in which it had been issued. ULP-D handed the inhaler to R6 and R6 inhaled one puff. R6 handed the inhaler back to ULP-D. ULP-D verified R6's inhaler lacked a prescription label or the original container for R6's inhaler. ULP-D looked in R6's upper locked cabinet in his apartment and found the original box the inhaler came in with an attached prescription label. ULP-D stated the original packaging with the label should be kept with the inhaler at all times. R10 On December 7, 2022, at 9:22 a.m., ULP-H was observed preparing R10's medications in R10's room to conduct a medication pass, which included R10's Advair Diskus 250-50 mcg, and fluticasone 50 mcg nasal spray. R10's medications were stored in R10's apartment in a locked drawer. R10's Advair Diskus inhaler had been removed from the original packaging and lacked an original prescription label with	01890		

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	28963	A. BUILDING: _____ B. WING _____	12/07/2022

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01890	Continued From page 40	01890		

information regarding the directions for use, medication name, medication dosage resident's name, and the pharmacy in which it had been issued. R10's fluticasone nasal spray had a prescription label; however, the label was illegible, and ULP-D was unable to determine when the nasal spray was opened and would expire. ULP-D verified R10's inhaler lacked an original prescription label and was unable to read the label on R10's nasal spray.

R9
On December 7, 2022, at approximately 12:50 p.m., the surveyor observed R9's opened Advair Diskus 250-50 mcg inhaler in a locked medication drawer in R9's room. The date the Advair Diskus inhaler was opened was written on the inhaler. Unidentified ULP looked in the drawer for a plastic bag, stating "normally there are plastic bags the inhalers come in with information on them." The ULP found a plastic bag in the drawer, however it was not for R9's Advair inhaler.

R9's prescriber orders, dated November 7, 2022, included Advair Diskus 250-50 mcg inhalation two times per day.

R9's opened Advair Diskus 250-50 mcg inhaler lacked an original prescription label with information regarding directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued.

EXPIRED MEDICATIONS/TIMED SENSITIVE MEDICATIONS

On December 7, 2022, at 9:22 a.m., R10's Albuterol Sulfate (to treat or prevent bronchospasm) was observed in the original

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01890	Continued From page 41 package; however, lacked an open date or date the inhaler would expire and was filled by the pharmacy on July 19, 2021. On December 7, 2022, at 9:40 a.m., licensed practical nurse (LPN)-G stated if a medication is without a label or the label is illegible, staff should notify the nurse to notify the pharmacy for a new label or make a temporary label. On December 7, 2022, at 12:34 p.m., director of nursing (DON)-B stated all medications should have original prescription labels and time sensitive medications should have the date the medication was opened and would expire. DON-B stated the LPN completed a monthly audit on all resident medications and it was the responsibility of all staff administering medications to look for expired medications and proper labeling. The licensee's Storage of Medications policy reviewed April 2022, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The licensee's Administration of Medication by Unlicensed Personnel policy reviewed July 2022, indicated all medications need to be checked for expiration date prior to administration and note the class of medications that require a date upon opening.	01890		

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01890	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of four residents (R3) with oxygen 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, 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).	01960		

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01960	Continued From page 43 The findings include: On December 6, 2022, at 7:04 a.m., the surveyor observed R3 lying in bed not wearing an oxygen cannula [a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen]. The surveyor observed unlicensed personnel (ULP)-E assisting R3 to the bathroom in R3's room. ULP-E commented R3 did not have "oxygen" on, adding, "we will get it [oxygen cannula] on when we get in there [bathroom]". The surveyor observed an oxygen cannula laying on the floor in R3's bathroom. On December 6, 2022, directly following the above observation ULP-E stated R3's oxygen was to be worn 24 hours a day, adding "she" [ULP-E] should have brought the oxygen cannula to R3 prior to having R3 ambulate to the bathroom from her bed. R3's diagnoses include anemia, hypoxia, and anxiety. R3's Service Plan dated July 1, 2022, included oxygen management daily, two liters per minute, continuously. R3's prescriber order dated December 17, 2021, included two liters of oxygen continuously. R3's treatment Recap Summary dated November 1, 2022, through December 4, 2022, included oxygen management three times a day, each shift. On December 7, 2022, at 8:13 a.m., director of nursing (DON)-B stated R3 is a "tough one." DON-B added her expectation was that staff put	01960		

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01960	Continued From page 44 the nasal cannula back on R3 or offer the oxygen [nasal cannula] to her. The licensee's Implementation of Medication Prescriptions, Treatment and Therapy Orders reviewed July 2022, indicated the registered nurse was responsible for assuring that the prescriptions and orders have been implemented appropriately through resident monitoring, supervision of staff and review of resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	02310		

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02310	Continued From page 45 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: STORAGE AREA On December 5, 2022, at 11:35 a.m., during a tour of the assisted living facility the surveyor observed an oxygen tank in a storage area on the main floor of the facility which was not stored in a rack or holder to secure the oxygen tank. On December 5, 2022, directly following the above observation licensed assisted living director (LALD)-A commented the facility was waiting on Hospice to pick up the oxygen tank. LALD-A confirmed the oxygen tank was not stored in a rack and acknowledged the tank should have been secured. RESIDENT ROOM On December 5, 2022, at 11:40 a.m., during a tour of the memory care unit the surveyor observed in R3's closet: - two small oxygen tanks unsecured; - eight small oxygen tanks secured in a rack; - one large oxygen tank unsecured; and - four large oxygen tanks secured in a rack. On December 5, 2022, directly following the above observation director of nursing (DON)-B stated the oxygen tanks were to be secured. The surveyor observed DON-B move an oxygen tank into a rack at that time. Minnesota Department of Health guidance,	02310		

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02310	Continued From page 46 Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/05/22*
Time: 11:32:13
Report: 7939221211

Food and Beverage Establishment Inspection Report

Location:
River Grand Assisted Living
355 River Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0020166
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
River Grand, Inc.

Phone #: 2189995333
ID #: 24703

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

The following orders were issued during this inspection.

3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A ** Priority 1 **

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

COOK WAS PEALING HARD BOILED EGGS WITH BARE HANDS. EGGS TOSSED OUT AND REST OF EGGS PEALED WITH GLOVED HANDS

Corrected on Site

Surface and Equipment Sanitizers

SMARTPOWER: = at Degrees Fahrenheit
Location: DISPENSER WITHIN LIMITS
Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BRISKET
Temperature: 192 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: BRISKET
Temperature: 187 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: BEAN SOUP
Temperature: 150 Degrees Fahrenheit - Location: STEAM TRAY
Violation Issued: No

Process/Item: CHICKEN
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN
Violation Issued: No

Process/Item: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: FLAT TOP FRIDGE
Violation Issued: No

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

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 7939221211 of 12/05/22.

Certified Food Protection Manager: MAUREEN EVENSON

Certification Number: FM108962 Expires: 02/17/25

Signed: N A

ANGIE STOLLEY
MANAGER

Signed:

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us