Electronically Delivered

December 20, 2021

Administrator
Elk Ridge Alzheimer's Special
1700 Beam Avenue
Maplewood, MN 55109

RE: Project Number(s) SL34426015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 17, 2021, 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.

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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.

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

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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

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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#34426015 On, November 16 through November 17, 2021 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 42 residents 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.A 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.	
0 480 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: (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. This had the potential to affect all 42 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 16, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 650 SS=B	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain employee records with all required content for three of three personnel (registered nurse (RN)-A, licensed practical nurse	0 650		

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0 650	Continued From page 3 (LPN)-E, and unlicensed personnel (ULP)-G) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a 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: RN-A RN-A was hired on August 9, 2021, to provide direct care services as well as supervise services and unlicensed personnel of the assisted living with dementia care licensed facility. RN-A's employee record lacked the documentation of the following required orientation: -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints and where to report complaints; -review of the types of assisted living services provided under the scope of the provider's license; and -principles of person-centered planning and service delivery. During an interview on November 17, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B verified RN-A's record lacked the above assisted living orientation, although LALD-B confirmed RN-A had received the orientation. LPN-E LPN-E had a hire date of October 15, 2021.	0 650		

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0 650	Continued From page 4 On November 17, 2021, at 8:07 a.m., LPN-E was observed to administer medications to R2. LPN-E's employee record lacked a position description. During an interview on November 17, 2021, at 12:17 p.m., LALD-B verified LPN-E's record lacked a position description. LALD-B stated LPN-E was given a position description at hire. ULP-G ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee record lacked documentation of the following required orientation: -overview of assisted living statutes; -review of provider's policies and procedures; -handling of resident complaints, reporting of complaints and where to report complaints; -review of the types of assisted living services provided under the scope of the provider's license; and -principles of person-centered planning and service delivery. During an interview on November 17, 2021, at 1:30 p.m., LALD-B confirmed the orientation outlined above was lacking from ULP-G's employee record, although LALD-B confirmed ULP-G had received the orientation. The licensee's Personnel Records dated August 1, 2021, indicated each employee record would include record of orientation.	0 650		

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0 650	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a screening for active and latent TB for two of three employees (registered nurse (RN)-A and unlicensed personnel (ULP)-G) with records reviewed. This had the potential to affect all 42 residents.	0 660		

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0 660	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment, dated October 14, 2021, indicated the facility was low risk for TB. RN-A RN-A was hired on August 9, 2021, to provide direct care and supervision of services and unlicensed personnel. RN-A's employee file lacked documentation of a completed two-step mantoux or other method of screening for active or latent TB. RN-A's employee file included a TB Test Documentation Form dated August 4, 2021, which indicated RN-A received a one-step mantoux although the form lacked results of the test and a second mantoux and results. ULP-G ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee record lacked documentation of a completed two-step mantoux or other method of screening for active or latent TB.	0 660		

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0 660	Continued From page 7 During an interview on November 17, 2021, at 1:30 p.m., licensed assisted living director/LALD-B confirmed ULP-G's employee file lacked documentation of completed screening for active or latent TB although he confirmed it was previously completed, however, the licensee's employee health files had been destroyed/lost by a previous employee. The licensee's TB Prevention and Control policy dated August 24, 2021 indicated all employees would be screened for TB by assessing for current symptoms of active TB, assessing for TB risk factors and TB history, and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST (tuberculin skin test) or single IGRA (interferon gamma release assays). 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;	0 680		

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0 680	Continued From page 8 (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 interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all 42 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 16, 2021, at approximately 10:00 a.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor.	0 680		

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0 680	Continued From page 9 The licensee's plan dated August 1, 2021, lacked the following: -an assessment of the at risk population's needs; -identification of which staff could assume specific roles and who was authorized to act in the absence of the administrator; -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -development of a policy and procedure to address the system of medical documentation that preserves resident information, protects confidentiality and secures/maintains availably of records; and -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On November 17, 2021, at 10:30 a.m., licensed assisted living director (LALD)-B stated the emergency preparedness plan was a work in progress, and he was aware not all components had been completed in the plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730		

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0 730	Continued From page 11 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for four of four residents (R1, R2, R3 and R4) with records reviewed. This had the potential to affect all 42 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3 and R4's medical records lacked documentation of services received. R1's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, osteoarthritis, and diabetes mellitus. R1's service plan, dated December 22, 2020, indicated the resident received services which included medication administration, housekeeping, laundry, assistance with bathing	0 730		

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0 730	Continued From page 12 1-2 times weekly, reminders/cueing for meal consumption. R1's service record for November 2021 included, but was not limited to, the following scheduled services: dressing, grooming, bathing, and eating. R1's service record lacked any documented services or refusals of bathing from November 1-15, 2021. R1's record further lacked the following documentation for November 1-15, 2021: - 28 of 45 scheduled services for dressing; - 28 of 45 scheduled services for grooming/oral hygiene; and - 22 of 30 scheduled services for eating. R2's diagnoses included, but were not limited to, type II diabetes, dementia, repeated falls, acute kidney failure, and heart disease. R2's service plan dated January 21, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, transfers, assistance with bathing 1-2 times weekly, grooming/hygiene at least twice daily, dressing, toileting, and eating. R2's service record for November 2021 included the following scheduled services: dressing, grooming, bathing, eating, transfers, and toileting. R2's service record lacked any documented services or refusals of bathing from November 1-15, 2021. R2's record further lacked the following documentation for November 1-15, 2021: - 27 of 45 scheduled services for dressing; - 27 of 45 scheduled services for grooming/oral hygiene; - 22 of 30 scheduled services for eating; - 27 of 45 scheduled services for transfers; and	0 730		

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0 730	Continued From page 13 - 28 of 45 scheduled services for toileting. R3's diagnoses included, but were not limited to, Alzheimer's disease, dementia with Lewy bodies, metabolic encephalopathy, and heart failure. R3 was also received hospice services. R3's Service Plan and Service Plan Detail, identified as part of the service plan, respectively dated September 22, 2020, and January 13, 2021, indicated the resident received services which included medication management, assistance with bathing 1-2 times weekly, grooming/hygiene at least twice daily, dressing, toileting, eating, transfers, laundry and housekeeping. R3's service record for October and November 2021, included, but were not limited to the following scheduled services: dressing, grooming, bathing, eating, transfers, repositioning and toileting. R3's services record lacked any documented refusals of services. R3's service record lacked the documentation of the following services were provided from October 10, 2021, thru November 15, 2021: - 23 of 74 scheduled services for dressing; - 23 of 74 scheduled services for grooming/oral hygiene; - 2 of 10 scheduled services for bathing; - 46 of 111 scheduled services for eating; - 37 of 111 scheduled services for transfers; - 58 of 111 scheduled services for repositioning; and - 58 of 111 scheduled services for toileting. R4's diagnoses included, but were not limited to, dementia, anxiety disorder, depression, brief psychotic disorder, delusional disorder, Alzheimer's disease and transient global	0 730		

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0 730	Continued From page 14 amnesia. R4's service plan and Service Plan Detail, identified as part of the service plan, respectively dated May 21, 2019, and January 14, 2021, indicated the resident received services which included medication management, assistance with bathing 1-2 times weekly, grooming/hygiene at least twice daily, dressing, toileting, laundry and housekeeping. R4's service record for October and November 2021 included, but were not limited to the following scheduled services: dressing, grooming, bathing and toileting. R4's service record lacked any documented refusals of services. R4's service record lacked documentation of the following services were provided from October 24, 2021, thru November 16, 2021: - 16 of 48 scheduled services for dressing; - 16 of 48 scheduled services for grooming; - 2 of 6 scheduled services for bathing; and - 39 of 72 scheduled services for toileting. On November 17, 2021, at 9:15 a.m., registered nurse (RN)-A and RN-C acknowledged the service documentation for the above residents had many undocumented services. RN-C stated, "We know it's [documentation] bad due to agency staff" and further indicated the licensee was reviewing alternative ways to capture documentation of services for all residents. The licensee's Contents of Resident Records policy dated August 24, 2021, indicated records were maintained for each resident to include documentation that services have been provided as identified in the service plan. No further information was provided.	0 730		

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0 730	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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.	0 810		

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0 810	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a fire safety and evacuation plan with all required and to provide the documentation on required staff training and training frequency related to fire safety and similar emergency evacuation. This has the potential to directly affect the safety of all 42 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 17, 2021, survey staff was on site between 9:12 a.m. and 3:20 p.m, and toured the facility with maintenance (M)-I. On November 17, 2021, at approximately 9:20 a.m., survey staff received the facility fire safety and evacuation plan documentation and records for review from M-I. At approximately 2:20 p.m., survey staff requested from the licensed assisted living director (LALD)-B for any additional training records for staff training. Survey staff received from LALD-B a printout list of online training documentation of new employees from Educare Learning System on emergency preparedness which included fire safety; however, no documentation was provided for the required	0 810		

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0 810	Continued From page 17 additional training of employees thereafter. The facility fire safety and evacuation plan documentation failed to provide: -Documented policy to include the required training of all employees on fire safety and evacuation plans and procedures for the minimum required training upon hire and thereafter, twice a year for all residents. -The record to show the frequency of the minimum required training on fire safety and evacuation plan of twice a year upon receiving the new employee online training. -Documentation on facility-specific procedures for all residents to address unique situations of residents needing assistance during a fire or similar emergency. The facility fire safety documentation, Relocation of Residents Within the Facility dated October 10, 2017, only addressed ambulatory residents but no written instructions for addressing non-ambulatory or bedridden residents. -The content to identify the meeting location of egress discharge outside of building for an outside evacuation . On November 17, 2021, at approximately 3:05 p.m., these findings were verified during the interview with the LALD-B and M-I. M-I stated that he has provided training at least annually but have not kept records; however, he will schedule the required additional training and maintain required documentation for records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 18	01290		
01290 SS=D	144G.60 Subdivision 1 Background studies required (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 interview and record review, the licensee failed to ensure a backgrount study was completed as required for one of three employees unlicensed personel ((ULP)-G) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1,	01290		

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01290	Continued From page 19 2021. ULP-G's employee file lacked documentation of a current background study. During an interview on November 17, 2021, at 1:30 p.m., LALD-B confirmed ULP-G's original background study was not in her employee file. Licensed assisted living director (LALD)-B stated he had instructed ULP-G and nursing supervisors that ULP-G could not work unsupervised or independently until a cleared background study was received. LALD-B provided confirmation of the staffing schedule which demonstrated ULP-G was re-scheduled to work with a partner. The licensee's Personnel Records dated August 1, 2021, indicated each employee record would include documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01290		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe	01370		

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01370	Continued From page 20 environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee unlicensed personnel (ULP)-G to include all required content with records reviewed. This practice resulted in a level two violation (a	01370		

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01370	Continued From page 21 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: ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee file lacked documentation of training and competency evaluations for the following topics: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. On November 16, 2021, at approximately 1:30 p.m., ULP-G was observed to provide personal hygiene and toileting assistance to R3. On November 17, 2021, at 1:30 p.m., licensed assistance living director (LALD)-B confirmed ULP-G's employee record lacked documentation of training and competency evaluation for the above topics, as required.	01370		

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01370	Continued From page 22 The licensee's Personnel Record dated August 1, 2021, indicated each personnel record would include record of all required training for unlicensed personnel and competency determinations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee unlicensed personnel (ULP)-G to include all required content with records	01380		

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01380	Continued From page 23 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee file lacked documentation of training and competency evaluations for the following topics: - reading and recording temperature, pulse and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - other RN/professionally delegated tasks. On November 16, 2021, at approximately 1:30 p.m., ULP-G was observed assisting ULP-F transfer R3 from a Broda chair to bed via Hoyer lift. On November 17, 2021, at 1:30 p.m., licensed assistance living director (LALD)-B confirmed ULP-G's employee record lacked documentation of training and competency evaluation for the above topics, as required.	01380		

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01380	Continued From page 24 The licensee's Personnel Record dated August 1, 2021 indicated each personnel record would include record of all required training for unlicensed personnel and competency determinations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01380		
01420 SS=D	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 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 training and competency to delegated tasks to include use of Broda chair and Hoyer lift for one of one employee unlicensed personnel (ULP)-G with records reviewed.	01420		

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01420	Continued From page 25 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: ULP-G started employment on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee record lacked documentation ULP-G had been trained or demonstrated competency to using a Broda chair or Hoyer lift. On November 16, 2021, at 1:30 p.m., ULP-G was observed assisting ULP-F in transferring R3 from a Broda chair to bed via Hoyer lift. ULP-G stated she was trained to use both at previous jobs, and was not certain she had received training from the licensee. On November 17, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed ULP-G's employee file lacked documentation of training and competency to the use of a Broda chair or Hoyer lift. LALD-B said some employee records were destroyed by a prior employee of the licensee. The licensee's Personnel Record policy dated August 1, 2021, indicated each personnel record would include record of all required training for unlicensed personnel and competency determinations.	01420		

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01420	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

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01470	Continued From page 27 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review. the licensee failed to ensure orientation was provided to include all required content for one of three employees (licensed practical nurse (LPN)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01470		

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01470	Continued From page 28 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LPN-E had a hire date of October 15, 2021. On November 17, 2021, at 8:07 a.m., LPN-E was observed administering medications to R2. LPN-E's employee record lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144.G; -Handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Provider's scope of license and types of assisted living services the employee will provide; and -Review of the principles of person-centered planning and service delivery. During an interview on November 17, 2021, at 12:17 p.m., licensed assisted living director (LALD)-B verified LPN-E's orientation record did not include the above listed topics. The licensee's Personnel Record policy dated August 1, 2021, indicated each employee record would include record of orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an	01490		

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01490	Continued From page 29 understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure completion of required dementia training for two of three employees registered nurse (RN)-A and unlicensed personnel (ULP-G), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee holds an assisted living facility with dementia care license. RN-A was hired on August 9, 2021, to provide direct care and supervision of services and unlicensed personnel. RN-A's employee file included 3.75 hours of dementia training. ULP-G was hired on January 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-G's employee file included 5.25 hours of dementia training. During an interview on November 17, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed RN-A and ULP-G had not completed the required eight hours of dementia training. The licensee's Personnel Records policy dated	01490		

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01490	Continued From page 30 August 1, 2021 indicated each personnel record would include record of required in-service education for all staff providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01640 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was authenticated for four of four residents (R1, R2,	01640		

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01640	Continued From page 31	01640		

R3 and R4). This had the potential to affect all 42 residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1 was admitted on October 23, 2019, and received services to include medication management and assistance with bathing, meals, laundry and housekeeping.

R1's service plan dated December 22, 2020, lacked a signature of the resident or resident's representative.

R2 was admitted on November 9, 2020, and received services to include medication management, assistance with activities of daily living (ADLs), bathing, toileting, transfers, meals, activities, laundry and housekeeping.

R2's service plan, dated January 21, 2021, lacked a signature of the resident or resident's representative.

R3 was admitted on September 23, 2020, and received services to include medication management and assistance with ADLs, bathing, toileting, transfers, meals, activities, laundry and housekeeping.

R3's Service Plan and Service Plan Detail,

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01640	Continued From page 32 identified as part of the service plan, respectively dated September 22, 2020, and January 13, 2021, lacked a signature or other authentication by the licensee's representative and by the resident or resident's representative. R4 was admitted on May 21, 2019, and received services to include medication management and assistance with ADLs, bathing, toileting, meals, activities, laundry and housekeeping. R4's service plan and Service Plan Detail, identified as part of the service plan, respectively dated May 21, 2019, and January 14, 2021, lacked a signature or other authentication by the licensee's representative and by the resident or resident's representative. On November 17, 2021, at 9:15 a.m., registered nurse (RN)-C confirmed the service plan detail was the most current versions of the service plan, and she was unsure why the documents lacked signatures by the licensee's representative and the resident or resident's representatives. The licensee's Service Plan Contents dated August 24, 2021, indicated the service plan and any revisions to service plans would have a signature or other authentication by the community and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t	01650		

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01650	Continued From page 33 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for four of four residents (R1, R2, R3 and R4) with records reviewed. This had the potential to affect all 42 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01650		

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01650	Continued From page 34	01650		

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:

R1 was admitted on October 23, 2019, and received services to include medication management and assistance with bathing, meals, laundry and housekeeping.

R1's service plan dated December 22, 2020, lacked the method of monitoring staff providing services.

R2 was admitted on November 9, 2020, and received services to include medication management and assistance with activities of daily living (ADLs), bathing, toileting, transfers, meals, activities, laundry and housekeeping.

R2's service plan dated January 21, 2021, lacked the method of monitoring staff providing services.

R3 was admitted on September 23, 2020, and received services to include medication management and assistance with ADLs, bathing, toileting, transfers, meals, activities, laundry and housekeeping.

R3's service plan and Service Plan Detail, identified as part of the service plan, respectively dated September 22, 2020 and January 13, 2021, lacked the method of monitoring staff providing services.

R4 was admitted on May 21, 2019, and received services to include medication management and

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01650	Continued From page 35 assistance with ADLs, bathing, toileting, meals, activities, laundry and housekeeping. R4's service plan and Service Plan Detail, identified as part of the service plan, respectively dated May 21, 2019, and January 14, 2021, lacked the method of monitoring staff providing services. On November 17, 2021, at 9:15 a.m., registered nurse (RN)-C confirmed the services plans lacked the method of monitoring staff providing services. The licensee's Service Plan Contents dated August 24, 2021, indicated all assisted living residents would have an up-to-date service plan identifying services to be provided based on assessment by the RN, service plans would have a signature or other authentication by the community and by the resident, and would include: a description of the services provided, fees for services, frequency of each service according to resident assessment and resident preferences, schedule and methods of monitoring assessments, schedule and methods of monitoring staff providing services and a contingency plan to include the action to be taken if the scheduled service cannot be provided, information and method to contact the community, names and contact information of persons the resident wishes to have notified in an emergency, names and contact information of persons the resident wishes to have notified if there was a significant adverse change in the resident's condition and circumstances in which emergency medical services are not to be summoned. No further information was provided.	01650		

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01650	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	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	01730		

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01730	Continued From page 37	01730		

to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the individualized medication management plan included all required content for four of four residents (R1, R2, R3 and R4) with records reviewed. This had the potential to affect all 42 residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, osteoarthritis, and diabetes mellitus.

R1's medication management plan was dated November 16, 2021. No previous medication management plan was provided. The medication management plan did not include documentation of specific resident instructions relating to the

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01730	Continued From page 38 administration of medications. R2's diagnoses included, but were not limited to, type II diabetes, dementia, repeated falls, acute kidney failure, and heart disease. On November 17, 2021, at 7:40 a.m., licensed practical nurse (LPN)-E was observed attempting to administer medications to R2. R2 refused the medication due to being crushed. Unlicensed personnel (ULP)-G stated R2 prefers to take medications whole. R2's medication management plan was dated November 16, 2021. No previous medication management plan was provided. The medication management plan did not include documentation of specific resident instructions relating to the administration of medications. R3's diagnoses included, but were not limited to, Alzheimer's disease, dementia with Lewy bodies, metabolic encephalopathy, and heart failure. R3 also received hospice services. R3's medication management plan was dated November 16, 2021. No previous medication management plan was provided. R4's diagnoses included, but were not limited to, dementia, anxiety disorder, depression, brief psychotic disorder, delusional disorder, Alzheimer's disease and transient global amnesia. On November 17, 2021, at 7:45 a.m., LPN-E was observed attempting to administer medications to R4. R4 refused the medications. R4's medication management plan was dated	01730		

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01730	Continued From page 39 November 16, 2021. No previous medication management plan was provided. On November 16, 2021, at 2:53 p.m., licensed assisted living director (LALD)-B verified the medication management plans provided for R1, R2, R3, and R4 were completed and signed during the survey. On November 17, 2021, at 9:15 a.m., registered nurse (RN)-A confirmed she had developed the medication management plans for R1, R2, R3 and R4 after receiving the request for each during survey. The licensee's Medication, Treatment and Therapy Reminders policy dated August 24, 2021 indicated prior to providing any medication services, an RN would develop an individualized medication management plan based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must	01940		

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01940	Continued From page 40 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the individualized treatment and therapy plan included all required content for three of three residents (R1, R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 41 The findings include: During the entrance conference on November 16, 2021, at approximately 9:30 a.m., registered nurse (RN)-A confirmed the licensee provided treatment and therapy services to residents. R1's record lacked evidence of a written statement on the resident's service plan for the treatment and therapy services being provided to include wound care. R1's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, osteoarthritis, and diabetes mellitus. R1's Service Plan and Service Plan Detail, identified as part of the service plan, respectively dated October 23, 2019, and December 22, 2020, indicated resident "does not have any current skin issues". R1's most recent nursing assessment dated August, 19 2021, identified an active wound to R1's left heel beginning August 13, 2021. On November 16, 2021, at 1:30 p.m., R1 was observed sitting in a wheelchair wearing a soft boot on the left foot. R1's treatment and therapy management plan dated November 16, 2021, indicated R1 received treatments to include wound care, but lacked documentation of specific resident instructions relating to the treatments or therapy administration. No previous treatment and therapy management plan was provided. On November 17, 2021, at 11:30 a.m., RN-A verified R1 was currently receiving wound treatment that began in August 2021. RN-A further stated the service plan should be updated to include wound care treatment. R2's record lacked evidence of a written statement on the resident's service plan for the treatment and therapy services being provided to include blood glucose checks. R2's diagnoses included, but were not limited to,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 42	01940		

type II diabetes, dementia, repeated falls, acute kidney failure, and heart disease.
R2's Service Plan and Service Plan Detail, identified as part of the service plan, respectively dated November 10, 2020, and January 20, 2021, indicated resident "has orders from primary care to check blood sugars twice daily before meals for 7 days."
R2's record included a signed physician order dated November 1, 2021, indicating R2 should have a blood glucose check once daily before breakfast.
On November 17, 2021, at 8:31 a.m., licensed practical nurse, (LPN)-H was observed performing a blood glucose check for R2.
R2's treatment and therapy management plan dated November 16, 2021, indicated R2 received treatments to include blood glucose monitoring, but lacked documentation of specific resident instructions relating to treatment or therapy administration. No previous treatment and therapy management plan was provided.
R3's record lacked evidence of a written statement on R3's service plan for the services being provided to include oxygen management, puree diet and nectar thick liquids.
R3's diagnoses included, but were not limited to, Alzheimer's disease, dementia with Lewy bodies, metabolic encephalopathy, and heart failure. R3 also received hospice services.
R3's Service Plan and Service Plan Detail, identified as part of the service plan, respectively dated September 22, 2020, and January 13, 2021, indicated R3 does not require supplemental oxygen; however, R3 did require a mechanical soft diet with regular liquids.
R3's prescriber orders dated August 13, 2021, and October 4, 2021, included orders for puree diet and nectar thick liquid and oxygen at two liters per minute (LPM) as needed (PRN).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 43 On November 17, 2021, at approximately 8:00 a.m., LPN-E was observed administering medications to R3, crushed in pudding, and provided nectar thick water for R3. Oxygen was also observed in R3's room. R3's Individualized Treatment and Therapy Management Plan dated November 16, 2021, indicated R3 received hospice services; however, R3's plan lacked the following treatments: oxygen therapy, puree diet and nectar thick liquids. It was also identified the plan did not include a written statement of each service on the service plan. On November 17, 2021, at approximately 9:15 a.m., RN-A confirmed R3's record lacked evidence of a written statement on the service plan for the treatments. RN-A confirmed she had developed the Individualized Treatment and Therapy Management Plan for R3 after it was requested by a member of the survey team. RN-A confirmed the plan lacked all of the treatment services R3 received. On November 16, 2021, at 2:53 p.m., licensed assisted living director (LALD)-B verified the treatment and therapy management plans provided for R1, R2, R3, and R4 were completed and signed during the survey. The licensee's Medication, Treatment and Therapy Reminders policy dated August 24, 2021 indicated prior to providing any treatment or therapy reminders an individualized treatment management plan would be elevated. The licensee's Service Plan Contents policy dated August 24, 2021 indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment of the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 44	02310		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care 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 potenial to affect all 42 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 16, 2021, at 1:30 p.m., an unsecured oxygen cylinder was observed sitting behind a recliner in R3's room. Unlicensed personnel (ULP)-G stated she was not sure how the oxygen cylinder should be stored. On November 17, 2021, at 7:45 a.m., the unsecured oxygen cylinder was observed sitting behind the recliner in R3's room against the heater. The heater was on and was warm to the touch. Licensed practical nurse (LPN)-E confirmed oxygen was not to be stored near a heat source and moved the oxygen cylinder	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: _____ B. WING _____	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ALZHEIMER'S SPECIAL	1700 BEAM AVENUE MAPLEWOOD, MN 55109

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02310	Continued From page 45 across the room near the closet. The oxygen cylinder remained unsecured. On November 17, 2021, at 9:15 a.m., registered nurse (RN)-A confirmed she was aware R3's oxygen was unsecured, adding she had called the supplier to request a storage rack. RN-A stated the oxygen should not have been stored near a heat source. The licensee's policy Safe Oxygen Use and Storage, dated August 24, 2021, indicated oxygen tanks/cylinders not in use by residents should be stored in a dedicated room, in an upright position, and secured to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *11/16/21*
Time: 10:00:00
Report: 8041211350

Food and Beverage Establishment Inspection Report

Location:
Elk Ridge Alzheimer'S Special
1700 Beam Avenue
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0038244
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517790500
ID #:

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

The following orders were issued during this inspection.

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.

NO SMALL DIAMETER PROBE THERMOMETER ON SITE. NEW THERMOMETER IS ON ORDER.

Comply By: 11/23/21

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A TEMPERATURE INDICATOR TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE HIGH TEMP. DISH MACHINE. OPTIONS DISCUSSED DURING INSPECTION.

Comply By: 11/23/21

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.

NO SANITIZER (QUATERNARY AMMONIUM) TEST KIT ON SITE.

Comply By: 11/23/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

EYEWASH STATION IS CONNECTED TO THE HAND SINK BY THE COOKLINE. RE-LOCATE EYEWASH STATION.

Comply By: 01/16/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

REFRIGERATOR IN THE BACK DINING ROOM KITCHENETTE DOES NOT HAVE A THERMOMETER.

Comply By: 11/23/21

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HAND SINK IN THE BACK DINING ROOM KITCHENETTE DOES NOT HAVE A HANDWASHING SIGN OR POSTER.

Comply By: 11/23/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300 ppm at Degrees Fahrenheit
Location: kitchen sani bucket
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp. sink dispenser
Violation Issued: No

Utensil Surface Temp.: = at 168 Degrees Fahrenheit
Location: kitchen dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: walk-in cooler: chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: walk-in cooler: turkey
Violation Issued: No

Type: Full
Date: *11/16/21*
Time: 10:00:00
Report: 8041211350
Elk Ridge Alzheimer'S Special

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: walk-in cooler: yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

Inspection was completed with the food service director, Leslie Kemp. MDH HRD staff were also on site completing survey with Jessie Chenze the team lead.

Establishment has a main kitchen and a back dining room kitchenette that is not currently being used. Refrigerator is holding food that is not TCS.

Discussed the following:
Employee illness policy and logging requirements
Glove-use policy
Handwashing
Highly susceptible population requirements, including pastaurized vs. unpasteurized eggs.
Thermometer use and calibration
Date marking
Violations on this report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041211350 of 11/16/21.

Certified Food Protection Manager: Vince Daleiden Foley

Certification Number: fm96632 Expires: 12/11/21

Inspection report reviewed with person in charge and emailed.

Signed: _____
Leslie Kemp
Food Service Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us

Report #: 8041211350

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	11/16/21
No. of Repeat RF/PHI Categories Out	0	Time In	10:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Elk Ridge Alzheimer'S Special	Address	City/State	Zip Code	Telephone
	1700 Beam Avenue	Maplewood, MN	55109	6517790500

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038244		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/16/21

Inspector (Signature) Sarah Gosbey