Electronically Delivered

August 22, 2023

Licensee
Castle Ridge
615 Prairie Center Drive
Eden Prairie, MN 55344

RE: Project Number(s) SL21183015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21183	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE	615 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21183015-0 On July 24 through July 26, 2023, 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 43 active residents all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) during cares for 2 of 2 staff (registered nurse (RN)-H, unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure skin was disinfected prior to blood glucose (BG) testing for 1 of 2 staff (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-H RN-H was hired September 20, 2022, and provided supervisory and direct care services for	0 510		

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0 510	Continued From page 2 residents. On July 25, 2023, at 12:04 p.m., RN-H was observed to assist R3 with wound care, including cleansing and dressing change for a wound on the front of R3's left ankle. RN-H stated she changed R3's dressing twice per week, and all wound care was completed by the licensee. RN-H performed HH and donned gloves. RN-H gathered, laid out and opened packages of the needed supplies. RN-H removed a bandage from R3's left ankle. RN-H cleansed the area using normal saline. Without removing soiled gloves or performing HH, RN-H palpated (pressed to feel) the area around the open wound with gloved fingers. RN-H then removed a clean bandage from an opened package and applied mupirocin (antibiotic) and gentamycin (antibiotic) ointments to the bandage, mixed with a wooden tongue depressor, and applied it to the wound. RN-H then applied a clean non-adhesive dressing over the wound and secured it with cloth medical tape. RN-H returned supplies to the wound care kit, disposed of garbage, removed soiled gloves and performed appropriate HH. ULP-D ULP-D was hired November 11, 2022, and provided direct care services for residents. On July 25, 2023, at 11:45 a.m., ULP-D was observed to assist R6 with a blood sugar check. ULP-D gathered blood sugar monitor, lancet, and test strip and placed items on the table next to the resident. ULP-D washed her hands with soap and water, donned gloves, and, without first cleansing the site with alcohol, pierced residents' finger with a lancet. ULP-D gathered the drop of blood in test strip and resulted the test. ULP-D disposed of supplies, doffed gloves, deposited soiled gloves	0 510		

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0 510	Continued From page 3 in the trash and left the room without completing HH. On July 25, 2023, at 11:50 a.m. ULP-D stated training on the procedure for BG monitoring was completed by a RN during new hire training and stated the RN observed her for competency. ULP-D stated she was trained to complete the following steps to perform a BG check: HH, apply gloves, clean resident finger with alcohol, wipe first drop of blood away and gather next drop of blood in the strip, then place the strip in the machine and obtain results and record. ULP-D stated she did not clean the resident's finger because she forgot a step. On July 25, 2023, at 1:45 p.m., clinical nursing supervisor (CNS)-A stated RN's trained the ULP's on BG monitoring during new hire training. CNS-A stated training included hand hygiene to start the process then clean the resident's finger, poke finger with lancet, and produce one drip of blood and wipe with cotton ball then catch the next drop of blood with the test strip and place in the monitor and wait to result. Then clean up all the supplies and throw away supplies including the lancet in the sharp's container and finish with hand hygiene. On July 25, 2023, at 2:45 p.m., clinical nursing supervisor (CNS)-A stated it would be expected that staff would change gloves and perform HH during a dressing change, after removing the soiled dressing and cleaning, prior to applying ointments and a clean dressing. The Minnesota Department of Health (MDH) guidance, Wound Care Infection Prevention Recommendations for Long-Term Care Facilities, dated November	0 510		

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0 510	Continued From page 4 30, 2022, indicated, "During an individual resident's wound care, doff gloves every time when going from dirty to clean surfaces or supplies. Perform hand hygiene after doffing gloves and before reapplying clean gloves." The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients (residents) in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Infection Control Standard Precautions Hand Hygiene policy, undated, indicated "Hand Hygiene should be performed: a. Before and after contact with the resident b. Before performing an aseptic task c. After contact with blood or body fluids d. After contact with visibly contaminated surfaces e. After contact with objects in the resident's room f. Before donning personal protective equipment g. After removing personal protective equipment h. After using the restroom i. Before meals".	0 510		

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure personal health and medical information was kept private for one of five 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) 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 July 24, 2023, at 10:50 a.m., the surveyor observed an opened and unattended homecare resident binder on the counter in the communal	0 700		

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0 700	Continued From page 6 dining room of the secured memory care unit. The binder was open and displayed R7's medical history and medication list. At 10:51 a.m. licensed practical nurse (LPN)-E stated the binder should not be in the common space and took the book back to the resident's room. LPN-E stated she would talk to the homecare agency about possibly keeping the binders in the nursing office to be kept secure and private. On July 24, 2023, at 1:15 p.m., licensed assisted living director (LALD)-C stated there should be no resident information left in common areas and resident information should not be visible to anyone but the care team in secured locations. The licensee-provided HIPAA [Health Insurance Portability and Accountability Act] Privacy Rights policy, revised April 21, 2020, addressed hospice services and referenced federal hospice regulations in the policy document that were not applicable to the licensee's current licensure. The licensee's policy had not been updated to reflect 144G statutes on keeping medical records secure in the Assisted Living facility. The licensee lacked a policy and procedure to address how resident records were protected against unauthorized disclosure. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440		

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01440	Continued From page 7 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after tasks were delegated for one of one employee (unlicensed personnel (ULP)-D). 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).	01440		

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01440	Continued From page 8 The findings include: ULP-D started work at the licensee's facility on November 11, 2022. On July 24, 2023, between 11:45 a.m., and 12:00 p.m., the surveyor observed ULP-D complete a blood sugar check on R6. On July 24, 2023, between 1:30 p.m., and 2:00 p.m., the surveyor observed ULP-D attempted medication administration to R4 residing in the secured unit, resident t refused medications and ULP-D toileted and transferred R4. ULP-D's employee record lacked documentation of supervision within 30-calendar days after the date medication administration tasks were delegated, and thereafter as needed based on performance. On June 24, 2023, at 2:27 p.m., clinical nurse supervisor (CNS)-A stated licensee has not been tracking the 30-day supervisions. They were not aware they needed to document the 30-day supervision. CNS-A stated if we looked at ULP staff we would not find a form of tracking. CNS-A further stated RNs had been making sure staff were competent but had not been documenting it. The licensee's policy for MN AL (Minnesota Assisted Living) delegation and supervision dated August 9, 2022, indicated Supervision of Resident Assistants by a RN would be completed with direct supervision of the staff who performed a delegated task within 30-calendar days after the staff member began working and first performed the delegated resident task. No further information was provided.	01440		

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01440	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 10 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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 employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (Licensed Practical Nurse (LPN)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01500		

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01500	Continued From page 11 The findings include: LPN-E was hired July 16, 2021, and provided direct care services for residents of the facility. On July 24, 2023, at 1:30 p.m., LPN-E was observed to assist R4 with toileting. LPN-E's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 12 On July 25, 2023, at 3:20 p.m., licensed assisted living director (LALD)-C stated LPN-E had not been scheduled for annual training and had not completed any. LALD-C further stated all annual training topics were covered in the corporate annual training, but was not assigned to, nor completed by LPN-E. The licensee's Education & Training policy, revised April 2022, indicated, "Employees will receive orientation and ongoing training to assure they possess the competencies and skill sets necessary to provide services to meet the residents ' needs safely and in a manner that promotes each resident ' s rights, physical, mental and psychosocial well-being. Competency-based training will be consistent with their expected job roles, policies and procedures, position description and to meet professional standards of practice." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530		

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	21183	A. BUILDING: _____ B. WING _____	07/26/2023

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01530	Continued From page 13 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all Assisted Living Facility with Dementia Care (ALFDC) staff received eight hours of initial dementia care training within the first 80 working hours of employment, and two hours of dementia care training annually, for direct care employees, as required, for two of two employees (unlicensed personnel (ULP)-D), licensed practical nurse (LPN)-E). 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:	01530		

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01530	Continued From page 14 The licensee had a current ALFDC license, effective August 1, 2021. ULP-D ULP-D was hired November 11, 2022 and provided direct care services for residents. On July 24, 2023, at 11:45 a.m. surveyor observed ULP-D complete a blood sugar check on R8. ULP-D's employee record included four hours of documented training, which included the required topics, but lacked documentation of four hours of the initial eight hours of required dementia care training, completed within 80 working hours. LPN-E LPN-E was hired July 16, 2021, and provided direct care services for residents. On July 24, 2023, at 1:30 p.m., LPN-E was observed to assist R4 with toileting. LPN-E's employee record lacked documentation LPN-E completed two hours of annual dementia care training, as required. On July 24, 2023, at 1:15 p.m., licensed assisted living director (LALD)-C stated there was a corporate wide issue with the online training system not auto enrolling new hires for dementia orientation. The issue affected training from November 2022 to April 2023, and possibly caused some annual training to not be assigned. LALD-C confirmed that ULP-D was working independently from December 2022 to April 2023 without the completed dementia care training. LALD-C further stated the human resources (HR)	01530		

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01530	Continued From page 15 director should have been completing an audit of training, but audits were not initiated until after the issue was identified April 2023. The licensee's Dementia Training policy dated August 1, 2021, indicated, "[Licensee] provides specialized training in the area of Alzheimer's Disease and Related Disorders to its employees that also meet regulatory requirements and timelines." The policy further indicated, "employees who have not completed their initial dementia care training will not provide direct care independently", and "Annual training: employees will receive training on topics related to dementia care for each 12 months thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640		

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01640	Continued From page 16 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 R4 was admitted to the licensee on March 16, 2022. On July 24, 2023, at 1:30 p.m. surveyor observed unlicensed personnel (ULP)-D attempt medication administration, R4 refused due extreme agitation, ULP-D transferred resident from walker to chair and reported medication refusal to the nurse. R4's unsigned Service Plan dated July 11, 2023,	01640		

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01640	Continued From page 17 lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. R4's unsigned service plan from July 11, 2023, had added services from previously signed service plan dated March 16, 2022, to include daily redirection/ problem solving, laundry two times per week, daily morning and evening cares, lotion application three times daily. Added services increased the cost of services from $2,700.00 to $3,935.00. R5 R5 was admitted to the licensee on February 13, 2023. On July 25, 2023, at 9:00 a.m. surveyor observed ULP-G administer morning medications to R5. R5's Service Plan dated July 24, 2023, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. R5's unsigned service plan from July 24, 2023, had added services from previously signed service plan dated February 14, 2023, whuch included medication management added July 2, 2023, linen change added April 14, 2022, CPAP maintainiance added February 28, 2023, laundry added April 23, 2023, and sensory communication February 28, 2023. On July 25, 2023, at 11:40 a.m., licensed assisted living director (LALD)-C stated licensee had been behind on getting service plans signed. LALD-C further stated they needed to do some re-education and training with the nurses on the requirement of getting a signature by the resident or their representative, as required. On July 25, 2023, at 11:40 a.m., clinical nurse	01640		

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01640	Continued From page 18 supervisor (CNS)-A stated she had been updating the service plans as they recognized services were missing from auditing. CNS-A further stated this had been a system wide issue with getting resident or resident representatives' signature for any service change. CNS-A could not state how many residents this affected, and stated this was a large issue and would make a process change going forward. CNS-A stated R5's service plan was signed the previous day, after the surveyor requested to see R5's service plan. CNS-A acknowledged service plan changes had been made multiple times with no signature request until the previous day. The licensee's MN AL (Minnesota Assisted Living) Service Plans policy dated August 1, 2021, indicated all assisted living residents would have an up-to-date service plan identifying services to be provided based on the assessment by RN and/or other licensed professional. Service plans and any revisions to the service plan needed a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days.	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 19 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01940		

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01940	Continued From page 20 only occasionally). The findings include: R3 had diagnoses including chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease causing shortness of breath), and congestive heart failure. R3's comprehensive registered nurse (RN) assessment dated July 12, 2023, indicated R3, "Needs assistance with brace or prosthesis." The assessment further indicated R3 needed assistance with wound care to lower extremities, including a dressing change twice weekly to one wound, and daily topical medication applied to other wounds. R3's service plan dated June 26, 2023, indicated R3 received services including assistance with wound care. The service plan further indicated "Ted Assist/ace wraps" to be performed by unlicensed personnel twice daily with morning and afternoon cares. The service plan lacked indication the licensee provided assistance with a knee brace. KNEE BRACE R3's record included a provider order dated September 30, 2022, indicating, "Brace to Left knee" for left knee pain. On July 25, 2023, at 1:38 p.m., during an observation of cares, R3's knee brace was observed hanging on a towel bar in R3's bathroom. R3's record lacked a treatment and therapy management plan for R3's knee brace with the following required content:	01940		

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01940	Continued From page 21 -a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that would be delegated to unlicensed personnel; -procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 25, 2023, at 3:09 p.m., clinical nursing supervisor (CNS)-A stated R3 typically wore the knee brace every day, and staff assisted as needed. Licensed assisted living director (LALD)-C added R3 likely refused to wear the brace that day due to an off-site appointment. On July 26, 2023, at 11:32 a.m., CNS-A stated they would need to develop a treatment management plan for R3's knee brace with clear instructions for the unlicensed personnel (ULPs) to follow, including a wearing schedule and when to notify the nurse. WOUND CARE R3's record included provider orders dated June 7, 2023, indicating wound cares to right lower leg, and left lower leg and ankle be performed two times per week. On July 25, 2023, at 12:04 p.m., RN-H was observed to assist R3 with wound care.	01940		

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01940	Continued From page 22 On July 25, 2023, at 1:38 p.m., ULP-F was observed to assist R3 with wound care. R3's record lacked a treatment and therapy management plan for wound care with the following required content: -procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services. On July 25, 2023, at 1:58 p.m., ULP-F stated she would call the nurse if there was increased drainage, bleeding, or pain. ULP-F stated there were not instructions on the electronic medical record (EMR) that indicated when to notify the nurse regarding R3's wounds. On July 25, 2023, at 2:45 p.m., CNS-A stated instructions to contact the nurse regarding R3's wounds should be in the caregiver services in the EMR, and would not be found elsewhere. The licensee's AL Delegation and Supervision Policy dated August 9, 2022, indicated, "The RN will develop a service plan for providing the services according to the resident ' s needs and preferences. The RN shall provide initial direction by teaching the task utilizing the delegated task form and delegated task orientation form that includes: a. Proper procedure/ technique b. Any risks associated with the task c. Anticipated side effects d. Observation of the resident response and symptoms to watch for e. When to notify the RN; also, may be specified in service charting." No further information was provided.	01940		

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01940	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 staff followed provider treatment orders for one of four residents (R3). 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: R3 had diagnoses including chronic obstructive pulmonary disease (COPD, a chronic	01960		

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01960	Continued From page 24 inflammatory lung disease causing shortness of breath), and congestive heart failure. R3's comprehensive registered nurse (RN) assessment dated July 12, 2023, indicated R3 needed assistance with wound care to lower extremities, including a dressing change twice weekly to one wound, and daily topical medication applied to other wounds. R3's service plan dated June 26, 2023, indicated R3 received services including assistance with wound care. On July 25, 2023, at 12:04 p.m., RN-H was observed to assist R3 with wound care, including cleansing and dressing change for a wound on the front of R3's left ankle. RN-H stated she changed R3's dressing twice per week, and that all wound care was completed by the licensee. After removing the bandage from R3's left ankle, RN-H cleansed the area using normal saline. RN-H stated she was using normal saline to cleanse the wound. RN-H then applied antibiotic ointments as prescribed and dressed the wound. On July 25, 2023, at 1:38 p.m., ULP-F was observed to assist R3 with wound care. ULP-F asked R3 to go to the bathroom to complete the cares. ULP-F wet a washcloth with tap water and cleansed the wound gently with the washcloth. ULP-F stated she would not want to use soap because she would not want soap to go "in the hole itself". ULP-F then dried the area, applied cream to the wound, as prescribed, and dressed the wound with 2x2 gauze and medipore tape. R3's record included provider orders dated June 7, 2023, that indicated the following wound cares be performed two times per week:	01960		

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01960	Continued From page 25 -"Wound Dressing Change: Left lower leg Calcium deposits Wash with gentle soap and water or wound spray Apply Sodium Thiosulfate STS to all calcium deposit scabs Apply as directed; Cover with 2-2x2 sterile gauze Cover with Medipore 2" tape"; -"Wound Dressing Change: Right lower leg Calcium deposits Wash with gentle soap and water or wound spray Apply Sodium Thiosulfate STS to all calcium deposit scabs Apply as directed; Cover with 2-2x2 sterile gauze Cover with Medipore 2" tape"; and -"Wound dressing change: Left lateral ankle - Wash your hands with soap and water before you begin your dressing change and prepare a clean surface for dressings. Wash with gentle soap and water or wound spray; pat dry Mix gentamycin and Mupirocin and apply as directed to wound bed Cover with 2- 2x2 sterile gauze Cover with Medipore 2" tape." On July 25, 2023, at 2:45 p.m. clinical nursing supervisor (CNS)-A stated staff should follow the orders and written directions for wound care and if it says to cleanse with soap and water, they should. On July 26, 2023, at 11:32 a.m., CNS-A stated RN-H did not like to use wound cleanser for R3 and preferred to use normal saline. CNS-A stated, if that were the case, they should have requested an order change. The licensee's MN AL Treatment and Therapy Management policy dated March 7, 2023, indicated, "It is the policy of [licensee] to provide therapy/treatment to residents as needed based on request, physician orders, or clinical	01960		

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CASTLE RIDGE	615 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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
01960	Continued From page 26 assessment. The therapy/treatment is to be provided according to [licensee] policy and standards of practice. " No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/24/23*
Time: 11:56:54
Report: 7994231143

Food and Beverage Establishment Inspection Report

Location:
Castle Ridge
615 Prairie Center Drive
Eden Prairie, MN55344
Hennepin County, 27

Establishment Info:
ID #: 0037464
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529422100
ID #:

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

No NEW orders were issued during this inspection.

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

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
TOMATOES 40
PICKLES 38
SLICED MEATS 39
LETTUCE 40
HAM 40

BRATS 153 (HOT HOLDING)
BRATS 162 (HOT HOLDING)

CHICKEN 168 (COOK)

SANITIZERS:
DISHWASHER 169 F
DISHWASHER 163 F

Type: Full
Date: *07/24/23*
Time: 11:56:54
Report: 7994231143
Castle Ridge

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994231143 of 07/24/23.

Certified Food Protection Manager: Katies Bakkum

Certification Number: 104785 Expires: 12/31/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231143

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/24/23
Time In 11:56:54
Time Out

Castle Ridge	**Address** 615 Prairie Center Drive	**City/State** Eden Prairie, MN	**Zip Code** 55344	**Telephone** 9529422100
License/Permit # 0037464	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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
Surpervision			
1	IN OUT		
2	IN OUT N/A		
Employee Health			
3	IN OUT		
4	IN OUT		
5	IN OUT		
Good Hygenic Practices			
6	IN OUT N/O		
7	IN OUT N/O		
Preventing Contamination by Hands			
8	IN OUT N/O		
9	IN OUT N/A N/O		
10	IN OUT		
Approved Source			
11	IN OUT		
12	IN OUT N/A N/O		
13	IN OUT		
14	IN OUT N/A N/O		
Protection from Contamination			
15	IN OUT N/A N/O		
16	IN OUT N/A		
17	IN OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
19	IN OUT N/A N/O		
20	IN OUT N/A N/O		
21	IN OUT N/A N/O		
22	IN OUT N/A		
23	IN OUT N/A N/O		
24	IN OUT N/A N/O		
Consumer Advisory			
25	IN OUT N/A		
Highly Susceptible Populations			
26	IN OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
28	IN OUT		
Conformance with Approved Procedures			
29	IN OUT N/A		

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		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		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:** 07/24/23

Inspector (Signature) Crystal Elva