DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 30, 2023

Licensee
Assisted Living At North Ridge
5500 Boone Avenue North
New Hope, MN 55428

RE: Project Number(s) SL20257015

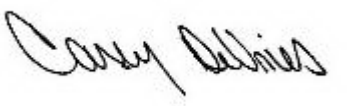
Dear Licensee:

On March 14, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

Electronically Delivered

February 15, 2023

Licensee
Assisted Living at North Ridge
5500 Boone Avenue North
New Hope, MN 55428

RE: Project Number(s) SL20257015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please email 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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: SL20257015-0 On December 12, 2022 through December 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was 118 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on December 13, 2022, issued for tag identification 2310. On December 14, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, isolated scope violation.	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 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.	
0 480 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 practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 14, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene. In addition, the licensee failed to properly disinfect shared blood glucose meters between residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 510		

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0 510	Continued From page 3 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During continuous observation on December 13, 2022, at 7:14 a.m. unlicensed personnel (ULP)-I administered oral medication to R7. ULP-I put on gloves, completed blood glucose check on R7, removed gloves, returned to medication cart and placed the facility shared Evencare G3 blood glucose meter in the top drawer. ULP-I failed to perform hand hygiene and failed to disinfect the blood glucose meter. ULP-I went to the office and took a new insulin pen from the medication refrigerator, returned to R7's room, placed gloves, administered insulin, assisted R7 to adjust his clothing, removed gloves, returned to medication cart, disposed of the needle, and placed the insulin pen in the cart. ULP-I then set up oral medications for R12. She gave R12 the oral medications, removed belbuca (a long-acting opioid pain medicine) from the cart, placed gloves, removed the film from the packaging and placed in R12's mouth against the inside of her cheek, and removed gloves. ULP-I removed the same facility shared blood glucose meter from the medication cart and put on gloves. When questioned about cleaning the meter, ULP-I stated she used an alcohol prep pad to clean it. ULP-I then completed blood glucose check on R12, used an alcohol prep pad to wipe the opening of the meter where the strip is inserted, and returned the meter to the medication cart. R12 requested ointment to knees and shoulder. ULP-I placed gloves, applied diclofenac 1% ointment (used to relieve joint pain) to bilateral knees and removed gloves. ULP-I placed gloves, applied lidocaine/hydrocortisone (used to relieve pain and itching) cream to her left shoulder, and	0 510		

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0 510	Continued From page 4 removed gloves. ULP-I began setting up medications for another resident. ULP-I failed to perform hand hygiene by washing hands or using hand sanitizer throughout the observation. On December 13, 2022, at 8:32 a.m., ULP-J removed a facility shared Evencare G3 blood glucose meter from the medication cart. ULP-J put on gloves, entered R13's room, completed a blood glucose check on R13, removed gloves and exited room. ULP-J used an alcohol prep to clean the opening of the blood glucose meter and stated that was how the staff were supposed to clean them. ULP-J removed an insulin pen from the medication cart, applied gloves and entered R13's apartment, she handed the insulin pen to R13 and observed self administration, removed gloves, and returned the insulin pen to the medication cart and used hand sanitizer. ULP-J stated staff were to use hand sanitizer between residents. On December 13, 2022, at 10:02 a.m. assistant director of nursing (ADON)-E stated staff were trained on handwashing every six months. Staff were to wash hands when visibly soiled, after using the bathroom, and after breaks. During medication passes staff should be washing hands after any contact with a resident and in between resident cares. Staff had access to wash hands in the nursing office and in the bathrooms on each floor. On December 13, 2022, at 10:30 a.m., LPN-K stated use of alcohol prep pads to clean the facility shared blood glucose meters was insufficient to disinfect them and staff were trained after each use they were to be cleaned using Medline Micro Kill bleach germicidal wipes.	0 510		

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0 510	Continued From page 5 On December 14, 2022, at 12:53 p.m. ADON-E stated the blood glucose meters should have been cleaned with the Medline Micro Kill bleach germicidal wipes. Regional nurse consultant (RNC)-B agreed with ADON-E and stated she was unaware the facility was still using facility shared blood glucose meters and the facility would obtain blood glucose meters for each individual instead of shared meters. The licensee's 8.01 Infection Control Policy dated August 2021, identified the licensee "infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities." The Licensee's 8.09 Hand washing Policy dated August 2021, identified "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: · Before, during, and after preparing food · Before eating food · Before and after caring for someone who is sick · Before and after treating a cut or wound · After using the toilet · After changing diapers or cleaning up after someone who has used the toilet · After blowing your nose, coughing, or sneezing · After touching an animal or animal waste · After handling pet food or pet treats · After touching garbage" "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." "Alcohol-Based Hand Sanitizers (ABHS) should not be used as a replacement for proper hand	0 510		

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0 510	Continued From page 6 washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands." The licensee's 7.31 Blood Sugar Testing - Single Equipment Use policy dated August 2021, identified prior to testing blood sugar staff were to wash hands and apply gloves. After testing blood sugar staff were to remove gloves and wash hands. The policy did not address cleaning of the blood glucose meter. The Evencare G3 blood glucose monitoring system user guide, dated December 2018, identified the meter was approved for multiple patients in a clinical setting. The cleaning and disinfection procedures identified the meter "should be cleaned and disinfected between each patient." Medline Micro Kill bleach germicidal wipes was an approved product for cleaning and disinfecting the meter. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 7 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individual abuse prevention assessment and plan annually for three of six residents (R7, R12, R13). 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: R7 R7 was admitted under the comprehensive home care license on November 28, 2016, and was admitted under the assisted living facility with dementia care (ALFDC) license on August 1, 2021. R7's Abuse Prevention Plan dated October 6, 2021, identified R7 had areas of vulnerability and interventions were implemented to prevent abuse. No annual reassessment was identified in R7's medical record. R12 R12 was admitted under the ALFDC license on August 27, 2021.	0 630		

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0 630	Continued From page 8 R12's Abuse Prevention Plan dated August 27, 2021, identified R12 was susceptible to abuse from another individual including other vulnerable adults, she was at risk of abusing other vulnerable adults, and she was at risk for self-abuse. Interventions were implemented to prevent abuse. No annual reassessment was identified in R12's medical record. R13 R13 was admitted under the comprehensive home care license on October 15, 2020, and was admitted under the ALFDC license on August 1, 2021. R13's Abuse Prevention Plan dated November 9, 2021, identified R13 had areas of vulnerability and interventions were implemented to prevent abuse. No annual reassessment was identified in R13's medical record. On December 14, 2022, at 10:13 a.m. assistant director of nursing (ADON)-E stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. On December 14, 2022, at 2:19 p.m. regional nurse consultant (RNC)-B stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, identified the licensee "develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment	0 630		

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0 630	Continued From page 9 based on identified information." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 730 SS=D	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	0 730		

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0 730	Continued From page 10 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; (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 complete a discharge summary for one of one discharged resident (R1) 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: R1's progress notes identified on June 9, 2022, at 2:14 p.m. it was recommended to the resident that she go to the hospital for evaluation of leg	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 11 swelling, shortness of breath, blood pressure issues and she declined going in. On June 13, 2022, at 12:00 p.m. the licensee called the hospital "to get an update on resident. Resident is currently in the ICU and RN unavailable at this time." There were no further progress notes. R1's record included a letter from R1's family member dated September 20, 2022. The letter indicated R1's care needs had increased and she no longer met the criteria to reside at the assisted living facility, therefore she had been moved to a long term care facility. R1's record lacked evidence a discharge summary had been completed. On December 12, 2022 at 1:32 p.m. the interim director of wellness (IDOW)-D, stated staff should have completed a discharge summary for R1 but it had not been done. the licensee's 2.37 Resident Record - Documentation policy dated August 1, 2021, identified staff were to document in the resident record "all medications, services. treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

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ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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0 950	Continued From page 12 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer one of six residents (R12) the opportunity to identify a designated representative 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	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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0 950	Continued From page 13 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: R12's contract included a form identifying "Resident has the right to name an individual of their choice as "Designated Representative" for the purposes of receiving certain information and to whom Provider can go to with questions related to Resident's residency and care at The Residence at North Ridge. If a Responsible Person is party to this Contract and Resident fails to name and provide contact information for a Designated Representative, Provider will direct questions related to Resident's residency and care at The Residence at North Ridge to the Responsible Person. Resident may name as Resident's Designated Representative an individual serving as Resident's Responsible Person. Resident also has the right to decline to name a Designated Representative. regardless of whether an individual has agreed to execute this Contract as Resident's Responsible Person" It had 2 boxes the resident could mark to indicate if the resident wanted to designate a resident or declined to designate a resident. There was a place for the resident to name the designated resident and to sign the document. The document was not completed and all areas were blank. On December 14, 2022, at 9:09 a.m. assistant executive director (AED)-A stated the form to designate a representative should have been completed for R12. No further information was provided.	0 950		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 950	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=D	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for 2 of 6 residents (R2, R3) living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally. The findings include: On December 14, 2022, at 1:30 p.m., surveyor noted R2's Assisted Living with Dementia Contract dated May 1, 2021, included language	0 970		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 15 waiving the licensee's liability for health, safety, or personal property of a resident. On December 14, 2022, at 2:15 p.m., surveyor noted R3's Assisted Living with Dementia Contract dated September 1,2021, included language waiving the licensee's liability for health, safety, or personal property of a resident. R2 and R3's Assisted Living Contracts, included the following language indicating a waiver of liability: Page 15, section 2 "Indemnification": Resident will indemnify and hold harmless Provider, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal Injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents." On December 14, 2022, at 2:44 p.m., assistant executive director (AED)-A stated they were aware of the waiver of liability in the contract. AED-A further stated the contract was in the process of being updated. AED-A provided surveyor with a copy of the updated contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of	01060		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 16 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01060	Continued From page 17	01060		

licensee failed to provide a written notice with required content, to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R1). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation within four days as required.

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:

R1's progress notes identified on June 9, 2022, at 2:14 p.m. it was recommended to the resident that she go to the hospital for evaluation of leg swelling, shortness of breath, blood pressure issues and she declined going in. On June 13, 2022, at 12:00 p.m. the licensee called the hospital "to get an update on resident. Resident is currently in the ICU and RN unavailable at this time." There were no further progress notes.

R1's record included a letter from R1's family member dated September 20, 2022. The letter indicated R1's care needs had increased and she no longer met the criteria to reside at the assisted living facility, therefore she had been moved to a long term care facility.

R1's record failed to identify the resident, and the residents representative had been provided as soon as practible and the a written notice that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01060	Continued From page 18 contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record failed to identify Office of Ombudsman for Long-Term Care of the relocation within four days. On December 12, 2022 at 1:32 p.m. the interim director of wellness (IDOW)-D, stated the facility was unaware of the requirement and had not completed the required documentation or notifications for any emergency relocations. the licensee's 2.37 Resident Record - Documentation policy dated August 1, 2021, identified staff were to document in the resident record "all medications, services. treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident."	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01440	Continued From page 19 therapy tasks must be supervised by an 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 observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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.	01440		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01440	Continued From page 20 The findings include: ULP-G was hired March 22, 2022 and provided direct care services for the residents of the facility. ULP-G's record indicated ULP-G was trained and evaluated for competency on August 29, 2022, in oral medication administration. ULP-G's record did not include documentation of direct supervision by an RN within 30 days of ULP-G performing delegated nursing tasks, including medication administration. On December 13, 2022, at 8:15 a.m., ULP-G was observed administering medications to R5 and R6. On December 14, 2022, at 10:18 a.m., assistant director of nursing (ADON)-E verified ULP-G's record lacked 30-day supervision of medication administration or other delegated tasks. ADON-E stated licensee has one-on-one meetings with the ULP's to discuss a summary of ULP's progress, but do not conduct direct supervision of ULP's performing delegated tasks. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated licensee would provide direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for resident's and thereafter as needed based on performance. Furthermore, the licensee's policy stated, it would be the responsibility of the RN staff to ensure the supervision of ULP's would be done within the time frames outlined above.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01440	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conduct ongoing client monitoring and reassessment, not to exceed 90	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 22 calendar days from the last date of the assessment for three of six residents (R7, R12, R13). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7 R7 was admitted under the comprehensive home care license on November 28, 2016, and was admitted under the assisted living facility with dementia care (ALFDC) license on August 1, 2021. R7's medical record identified a Nursing Admission Evaluation dated October 6, 2021. R7's record failed to identify any 90 day assessments had been completed after October 6, 2021. R12 R12 was admitted under the ALFDC license on August 27, 2021. R12's medical record identified Nursing Admission Evaluation dated February 28, 2022 and September 22, 2022. There was 159 days between the assessments. R13 R13 was admitted under the comprehensive home care license on October 15, 2020, and was	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01620	Continued From page 23 admitted under the ALFDC license on August 1, 2021. R13's medical record identified a Nursing Admission Evaluation dated November 9, 2021. R13's record failed to identify any 90 day assessments had been completed after November 9, 2021. On December 14, 2022, at 10:13 a.m. assistant director of nursing (ADON)-E stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. On December 14, 2022, at 2:19 p.m. regional nurse consultant (RNC)-B stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, noted the registered nurse would conducted a nursing assessment of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier, and the RN assessment would include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by there RN who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 24	01710		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure reassessment and monitoring of medication management services for one of one resident (R13). 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). R13 On December 13, 2022, at 8:32 a.m., unlicensed personnel (ULP)-J was observed testing blood glucose and administering insulin to R13. R13 was admitted under the comprehensive home care license on October 15, 2020, and was admitted under the ALFDC license on August 1, 2021. R13's service plan dated October 15, 2020,	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01710	Continued From page 25 identified R13 received medication administration services. R13's medical record identified a Medication Review dated November 9, 2021. R13's record failed to identify an annual medication assessment had been completed. On December 14, 2022, at 10:13 a.m. assistant director of nursing (ADON)-E stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. On December 14, 2022, at 2:19 p.m. regional nurse consultant (RNC)-B stated she was aware some of the assessments had not been completed timely and the facility was working to correct the problem. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, noted the registered nurse would conducted a nursing assessment of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier, and the RN assessment would include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by there RN who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

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ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 26	01730		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

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ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 27 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 develop and maintain a current individualized medication management record for each resident to include all required content for four of four residents (R3, R7, R12, R13). 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 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: R3 On December 13, 2022, at 8:15 a.m., unlicensed personnel (ULP)-G was observed administering medications to R3. R3 was admitted under the comprehensive home care license on May 3, 2021, and was admitted under the assisted living facility with dementia care (ALFDC) license on September 1, 2021. R3's care plan, identified as the service plan, dated October 5, 2021, identified R3 received medication management services. R3's Medication Administration Assessment dated	01730		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 28 October 5, 2022, and the care plan failed to identify persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. R7 On December 13, 2022, at 7:14 a.m., unlicensed personnel (ULP)-I was observed testing blood glucose and administering oral medications and insulin to R7. R7 was admitted under the comprehensive home care license on November 28, 2016, and was admitted under the assisted living facility with dementia care (ALFDC) license on August 1, 2021. R7's care plan, identified as the service plan, dated November 15, 2021, identified R7 received medication management services. R7's Medication Administration Assessment dated October 6, 2022, and the care plan failed to identify persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. R12 On December 13, 2022, at 8:18 a.m., ULP-I was observed testing blood glucose and administering oral medications, ointments, and insulin to R12. R12 was admitted under the ALFDC license on August 27, 2021. R12's care plan, identified as the service plan, dated November 12, 2021, identified R12 received medication management services. R12's Medication Administration Assessment dated August 27, 2022, and the care plan failed to	01730		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 29 identify persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. R13 On December 13, 2022, at 8:32 a.m., ULP-J was observed testing blood glucose and administering insulin to R13. R13 was admitted under the comprehensive home care license on October 15, 2020, and was admitted under the ALFDC license on August 1, 2021. R13's service plan dated October 15, 2020, identified R13 received medication administration services. R13's Medication Review dated November 9, 2021 failed to identify persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On December 14, 2022, at 5:06 p.m. regional nurse consultant (RNC)-B stated identifying persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis was missing from the assessment and service plan, so none of the residents would have that information in their chart. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, noted the registered nurse would conducted a nursing assessment of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident	01730		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01730	Continued From page 30 moves in, whichever is earlier, and the RN assessment would include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by there RN who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure medications were administered according to manufacturer instructions for one of two residents (R7) receiving insulin. This had the potential to affect all 11 residents who received insulin administration.	01760		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 31 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 December 13, 2022, at 7:14 a.m. unlicensed personnel (ULP)-I was observed administering Humulin 70/30 insulin to R7. ULP-I failed to mix the insulin and prime the pen according to manufacturer instructions. On December 14, 2022, at 2:53 p.m. assistant director of nursing (ADON)-E stated staff should administer insulin according to manufacturer directions. Staff are trained to mix the insulin and prime the pen. The licensee's 7.36 Insulin policy dated August 1, 2021, identified "Roll the insulin between your hands to gently mix the insulin. Hand the resident the syringe and the insulin for them to draw up or dial up their insulin. Give them an alcohol wipe to clean the top of the insulin bottle." The policy lacked instructions for priming the insulin pen. Humulin 70/30 KwikPen instructions for use, dated June 2022, identified to mix the insulin by doing the following: "·Gently roll the Pen between your hands 10 times. ·Move the Pen up and down (invert) 10 times." "Mixing by rolling and inverting the Pen is important to make sure you get the right dose."	01760		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 32 "Prime before each injection." "Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly." "If you do not prime before each injection, you may get too much or too little insulin." ·To prime your Pen, turn the Dose Knob to select 2 units ·Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. ·Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. ·You should see insulin at the tip of the Needle." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for eleven of eleven residents (R18,	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01770	Continued From page 33 R22, R23, R24, R25, R26, R27, R28, R29, R30, R31). 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 December 13, 2022, at approximate 11:30 a.m.,licensed practical nurse (LPN)-K was noted to be setting up medication caddies in the nursing office. On December 14, 2022, at 11:55 a.m. LPN-K stated she does not document medication set-up. In the past there was a process for documenting medication set up, but things had been busy so she stopped doing it. Document titled "Mediset Residents" undated contained R18, R22, R23, R24, R25, R26, R27, R28, R29, R30, and R31's names. LPN-K stated that was the list of resident she completed weekly medication set up for. On December 14, 2022, at 12:53 p.m. assistant director of nursing (ADON)-E stated documentation of medication set up should be done in the progress notes and should include when it was set up and delivered. The licensee's 7 .08 Medication Management - Administration & Setup policy dated August 1, 2021, identified "The nursing staff and unlicensed	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01770	Continued From page 34 personnel trained to provide medication administration at The Residence at North Ridge will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened and had a pharmacy label in four of four medication carts reviewed. The licensee failed to ensure medication that was not administered and was no longer in the original container, labeled by the pharmacy, was placed in a separate area for destruction. 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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
01890	Continued From page 35 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 December 13, 2022, at 7:14 a.m., unlicensed personnel (ULP)-I was observed checking blood glucose and administering oral medications and insulin to R7 and R12 from medicaion cart A. On December 13, 2022, at 8:32 a.m., ULP-J was observed testing blood glucose and administering insulin to R13 from medication cart B. Review of medication carts was completed with licensed practical nurse (LPN)-K on December 13, 2022, at 10:00 a.m. and identified the following: Medication cart A (third floor) - R32 had two Lantus insulin pens. Neither pen had an open date. - R12 had three aspart insulin pens and 1 Basaglar insulin pen. None of the pens had an open date. - R13 had a Novolog mix 70/30 insulin pen and an aspart insulin pen. Neither of the pens had an open date. Medication cart B (third and fourth floor) - R13 had a Lantus insulin pen dated open October 27, 2022, and 2 Lantus pens with no open date. - R34 had a Levemir insulin with no open date, a Levemir pen dated open October 14, 2022, and a Novolin Flexpen that was undated. LPN-K stated R34 had been discharged approximately one month ago and medications should have been removed from the medication cart and destroyed.	01890		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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
01890	Continued From page 36 - R11 had 2 bottles of latanoprost (glaucoma) eye drops dated as opened on August 18, 2022 and November 30, 2022. - There was a bottle of latanoprost eye drops with an illegible label. The first name of the resident was legible and there was an open date on the bottle of August 3, 2022. LPN-K identified the bottle as belonging to R11 and stated it should have a legible pharmacy label to be used. - R35 had two bottles of timolol eye drops (glaucoma) one was dated open October 30, 2022, and the other bottle had no open date. Medication cart C (second floor) - R36 had two Humalog Kwikpen (insulin) pens with no open date, a lispro (insulin) pen with no open date, a Lantus insulin pen with no open date, and a Lantus pen with R36's name handwritten on the pen dated December 13, 2022. - R37 had a Novolog pen and a Basaglar pen. Neither pen had an open date. LPN-K stated he had discharged awhile ago and the medications should have been removed and destroyed. - A foil package with 3 vials of carbomethylcellulose sodium written on the vial. There was the room number "217" on the package. No other identifying information was present. Medication cart D (second floor) - R38 had Lantus Solostar insulin pen with no open date and a Humalog insulin pen with no open date. - A Lantus insulin pen with R39's first name initial and last name handwritten on the pen with an open date of November 12, 2022. There was no pharmacy label. - R40 had a Lantus Solostar insulin pen with no open date and a Lispro Quikpen (insulin) with no	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01890	Continued From page 37	01890		

open date
- R18 had a glargine insulin pen with no open date.
- There was a Humalog Kwikpen with no pharmacy label and no identifying information on the pen.

During the medication cart review on December 13, 2022, at 10:00 a.m. LPN-K stated staff were to write the date opened on the insulins and eye drops and were to discard them after that date. There should not have been multiple pens of the same medications for the residents in the cart and all meds should have a pharmacy label. Staff should be aware of how long the insulin is able to be used after it is opened as they are trained on that but was unsure if they were trained on how long eye drops are able to be used after the open date. There was no information readily available for the staff with how long medications were safe to use after they were opened. Audits were to be completed monthly on the medication carts by the licensed staff.

On December 13, 2022, at 10:35 a.m., review with LPN-K of a medication refrigerator, located in the locked nursing office, identified two plastic baskets labeled "extra insulin only use if resident is out". There were ten Novolog FlexPen's and five Humalog Kwikpen's in the baskets. None of the insulin pens had a pharmacy label on them. LPN-K stated the insulin pens were for staff to use for residents if they were out of insulin and the resident did not have any left. The insulin pens were from residents who either died or discharged and did not take the insulin with them. Rather then throw them away, they were kept in case they were needed for other residents.

On December 13, 2022, at 10:02 assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01890	Continued From page 38	01890		

director of nursing (ADON)-E stated expired medications should be removed from the medication cart and disposed of. Cart audits were done twice a week and weekly by the licensed staff. Further stated on December 14, 2022, at 3:11 p.m. she was unaware insulin was being saved from discharged or deceased residents, for use in other residents. Medications should never be saved and used for someone else. Staff should follow the six rights of medication administration.

The licensee's 7.23 Medication Disposal policy dated August 1, 2021, identified the following:
- Any current medications being managed by [the licensee] must be provided to the resident when the resident's service plan ends, or medication management services are no longer part of the service plan.
- Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.
- The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.
- Current unused medications managed by The Residence at North Ridge will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber.
- Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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
01890	Continued From page 39 date of disposition, and names of staff and other individuals involved in the disposition. NovoLog (aspart) FlexTouch pen prescribing information dated February 2015, identified "The NovoLog FlexTouch Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." Basaglar KwikPen prescribing information dated July 2021, identified "In-use BASAGLAR prefilled pens must be used within 28 days or be discarded, even if they still contain BASAGLAR." Levemir FlexTouch pen prescribing information dated January 2019, identified "The Levemir FlexTouch Pen you are using should be thrown away after 42 days, even if it still has insulin left in it." Latanoprost consumer information dated September 16, 2014, identified "must be used within 28 days after opening the bottle. Discard the bottle and/or unused contents after 28 days." Humalog (lispro) prescribing information, undated, identifies "The HUMALOG Pen you are using should be thrown away after 28 days, even if it still has insulin left in it." Lantus SoloStar prescribing information dated November 2018, identified "Once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days." Timolol eye drops manufacturer information dated June 2020, identified "Any contents remaining 4 weeks after opening should be discarded."	01890		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01890	Continued From page 40 Novolin N FlexPen prescribing information dated November 2022, identified "The Novolin N FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it." NovoLog mix 70/30 manufacturer information, undated, identified "Once a NovoLog Mix 70/30 FlexPen is punctured, it may be used for up to 14 days if it is kept at room temperature below 30°C (86°F)" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01900 SS=F	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription insulin pens prescribed to residents were not being saved for use by anyone other than the resident prescribed the insulin. This had the potential to affect 12 out of 12 residents receiving insulin. In addition the licensee failed to ensure a medication prescribed for one resident was not used for another resident. 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	01900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01900	Continued From page 41 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 December 13, 2022, at 7:14 a.m., unlicensed personnel (ULP)-I was observed administering oral medications R12. ULP-I removed a bottle of polyethylene glycol (constipation) from the cart, measured the medication into the cap and poured it into a medication cup. The surveyor observed the prescription label on the bottle identified R41's name, polyethylene glycol 17 grams by mouth daily. Surveyor intervened due to the prescription label was for the wrong resident. ULP-I stated it is ok because it is the same thing and removed another bottle from the cart with the prescription label which identified R12's name, polyethylene glycol 17 grams by mouth daily. On December 13, 2022, at 10:35 a.m., review with LPN-K of a medication refrigerator, located in the locked nursing office, identified two plastic baskets labeled "extra insulin only use if resident is out". There were ten Novolog FlexPen's and five Humalog Kwikpen's in the baskets. None of the insulin pens had a pharmacy label on them. LPN-K stated the insulin pens were for staff to use for residents if they were out of insulin and the resident did not have any left. The insulin pens were from residents who either died or discharged and did not take the insulin with them. Rather then throw them away, they were kept in case they were needed for other residents. On December 13, 2022, at 10:02 assistant director of nursing (ADON)-E stated expired medications should be removed from the	01900		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01900	Continued From page 42 medication cart and disposed of. Cart audits were done twice a week and weekly by the licensed staff. Further stated on December 14, 2022, at 3:11 p.m. she was unaware insulin was being saved from discharged or deceased residents, for use in other residents. Medications prescribed for a resident should never be used for someone else. Staff should follow the six rights of medication administration. The licensee's 7.36 Insulin policy dated August 1, 2021, identified "Insulin medications must be administered according to the prescriber's orders." "Medications always need to be administered according to the "6 Rights": -Right person -Right medication -Right time -Right route (i.e., by mouth, eye drop, to the skin) -Right dose (i.e., how many milligrams, drops) -Right chart/record to document that the medication was taken" "When administering medications, staff were to "Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -Resident name -Name of the medication -The strength and dosage of the medication The route -The time that the medication is to be given Any special instructions" If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same." The licensee's 7.23 Medication Disposal policy dated August 1, 2021, identified the following:	01900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01900	Continued From page 43 - Any current medications being managed by [the licensee] must be provided to the resident when the resident's service plan ends, or medication management services are no longer part of the service plan. - Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. - The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. - Current unused medications managed by [the licensee] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. - Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01910	Continued From page 44 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1) 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).	01910		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01910	Continued From page 45 The findings include: R1's progress notes identified on June 9, 2022, at 2:14 p.m. it was recommended to the resident that she go to the hospital for evaluation of leg swelling, shortness of breath, blood pressure issues and she declined going in. On June 13, 2022, at 12:00 p.m. the licensee called the hospital "to get an update on resident. Resident is currently in the ICU and RN unavailable at this time." There were no further progress notes. R1's record included a letter from R1's family member dated September 20, 2022. The letter indicated R1's care needs had increased and she no longer met the criteria to reside at the assisted living facility, therefore she had been moved to a long term care facility. R1's record lacked evidence a discharge summary had been completed. On December 12, 2022 at 1:32 p.m. the interim director of wellness (IDOW)-D, stated staff should have completed a disposition of medications for R1 but there was no record of it in R1's record. The medications had been disposed of but there was no documentation it had been done. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, identified "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided.	01910		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01910	Continued From page 46 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 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	01940		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 47 by: Based on observation, interview and record review, the licensee failed to ensure it developed an individual treatment management plan to include all required content for two of two residents (R7, R12) who received blood glucose monitoring. This had the potential to affect all 12 residents who received blood glucose monitoring services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R7 On December 13, 2022, at 7:14 a.m., unlicensed personnel (ULP)-I was observed checking blood glucose and administering insulin to R7. R7's care plan, identified as the service plan dated November 15, 2021, did not indicate the resident received blood glucose monitoring services. R7's Order Summary, printed December 14, 2022, unsigned, identified R7 had an order to "check resident's blood sugar three times a day". R7's medication administration record for December 1, 2022, through December 14, 2022, identified the licensee had checked R7's blood glucose three times per day every day.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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01940	Continued From page 48	01940		

R12
On December 13, 2022, at 7:45 a.m., ULP-I was observed testing blood glucose and administering insulin to R12.

R12's care plan, identified as the service plan dated November 12, 2021, did not indicate the resident received blood glucose monitoring services.

R12's order summary, reviewed by medical provider on December 1, 2022, identified R12 had an order to "record blood sugar three times daily".

R12's medication administration record for December 1, 2022, through December 14, 2022, identified the licensee had checked R12's blood glucose three times per day every day.

On December 14, 2022, at 5:10 p.m., regional nurse consultant (RNC)-B stated there is no section on the assessment that identifies blood glucose monitoring, therefore it would not be on any of the residents care plans/service plans.

The licensee's Medication &Treatment policy dated August 1, 2021, identified, the licensee "will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:
a. A statement of the type of services that will be provided
b. Documentation of specific resident instructions relating to the treatments or therapy administration
c. Identification of treatment or therapy tasks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01940	Continued From page 49 that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02110 SS=D	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic	02110		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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02110	Continued From page 50 medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the assisted living with dementia licensee failed to ensure the required policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in for two of two residents (R3 and R4). 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's record was reviewed. R3 was admitted to the licensee on September 1, 2021. R3's record	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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02110	Continued From page 51 lacked documentation of receipt of required policies and procedures to be provided by licensee at the time of move-in. R4's record was reviewed. R4 was admitted to the licensee on September 21, 2022. R4's record lacked documentation of receipt of required policies and procedures to be provided by licensee at the time of move-in. On December 14, 2022, at 2:12 p.m., regional nurse consultant (RNC)-B stated the policy packet was created but was not provided to any residents receiving services by the licensee. RN-C stated the licensee did not realize it was a requirement to provide the policies and procedures to the residents. The licensee's Assisted Living with Dementia Care Additional Required Policies dated August 1, 2021, indicated all policies and procedures required would be provided to residents and the resident's legal and designated representatives at the time of move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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02240	Continued From page 52 understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by:	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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
02240	Continued From page 53 Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for six of six residents (R2, R3, R4 ,R7, R12, R13). 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: R2 R2 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) licensee on September 1, 2021. On December 13, 2022, at 1:30 p.m., R2's record lacked evidence of a written acknowledgement the resident received the current assisted living bill of rights. R3 R3 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) licensee on May 1, 2021. On December 13, 2022, at 8:15 a.m., unlicensed personnel (ULP)-G was observed administering medications to R3. On December 13, 2022, at 2:15 p.m., R3's record lacked evidence of a written acknowledgement	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

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02240	Continued From page 54 the resident received the current assisted living bill of rights. R4 R4 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) licensee on September 1, 2021. On December 13, 2022, at 2:45 p.m., R4's record lacked evidence of a written acknowledgement the resident received the current assisted living bill of rights. R7 R7 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) licensee on August 1, 2021. On December 13, 2022, at 7:14 a.m., unlicensed personnel (ULP)-I was observed checking blood glucose, administering insulin, and administering medications to R7. R7's record lacked evidence of a written acknowledgement the resident received the current assisted living bill of rights. R12 R12 was admitted to the ALFDC licensee on August 27, 2021. On December 13, 2022, at 7:45 a.m., ULP-I was observed testing blood glucose and administering medications to R12. R12's record lacked evidence of a written acknowledgement the resident received the current assisted living bill of rights. R13	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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
02240	Continued From page 55 R13 was admitted to the ALFDC licensee on August 1, 2021. On December 13, 2022, at 8:32 a.m., ULP-J was observed testing blood glucose and administering insulin to R13. R13's record lacked evidence of a written acknowledgement the resident received the current assisted living bill of rights. On December 14, 2022, at 9:05 a.m., assistant executive director (AED)-A stated she was unaware of the updated Assisted Living Bill of Rights dated August 2022, therefor none of the residents had received it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for five of five residents (R8, R10, R7, R11, R12) with side rails. This resulted in an immediate order issued on	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 56 December 13, 2022, at approximately 5:15 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2022, the director of maintenance (DOM)-F provided a document identified as "residents with siderails" dated November 2022. The document identified a list of residents which included, but was not limited to, R8, R10, R7, R11, and R12. There were 3 columns which identified the resident, zone 1-3 and zone 4. R8 R8 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R8's measurements listed on the "residents with siderails" dated November 2022, identified the following: Zone 1-3 - 3 3/4 inches Zone 4 - 2 3/8 inches On December 13, 2022, at 1:28 p.m., surveyor observed an upper half siderails on the left side of R8's bed. Assistant director of nursing (ADON)-E measured zones 1-4 with the following findings: Zone 1 - 4 ¼ inches and 3 inches Zone 2 - 0 inches	02310		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 57 Zone 3 - 2 inches Zone 4 - 0 inches ADON-E confirmed the measurements on the "residents with siderails" document was not accurate. Review of R8's electronic medical record failed to identify an assessment for siderail use had been completed or that risk versus benefits had been discussed with resident or responsible party. R10 R10 began receiving services under the ALFDC license on August 1, 2021. R10's measurements listed on the "residents with siderails" dated November 2022, identified the following: Zone 1-3 - 2 3/4 inches Zone 4 - 2 3/8 inches On December 13, 2022, at 1:15 p.m., surveyor observed bilateral upper half siderails on R10's bed. ADON- E measured zones 1-4 with the following findings: Zone 1 - 4 1/2 inches and 3 inches Zone 2 - 0 inches Zone 3 - 1 inches Zone 4 - 0 inches ADON-E confirmed the measurements on the "residents with siderails" document was not accurate. Review of R10's electronic medical record failed to identify an assessment for siderail use had been completed or that risk versus benefits had been discussed with resident or responsible party.	02310		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 58 R7 R11 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R7's measurements listed on the "residents with siderails" dated November 2022, identified the following: Zone 1-3 - 3 3/4 inches Zone 4 - 2 3/8 inches On December 13, 2022, at 1:35 p.m. surveyor observed bilateral wide U-shaped consumer siderails on R7's bed. They extended under the mattress and they were secured on the opposite side of the bed frame with a strap. ADON-E stated the measurements on the "residents with siderails" document were inaccurate. She was unaware if the licensee had a copy of the manufacturer's instructions for the siderail and she was unable to confirm that the side rail was installed correctly. She was unaware if the facility had checked the Consumer Product Safety Commission (CSPC) for recalls. It was not the facilities process to check the manufacturer instructions or the CSPC. Review of R7's electronic medical record failed to identify an assessment for siderail use had been completed or that risk versus benefits had been discussed with resident or responsible party. R11 R12 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R11's measurements listed on the "residents with siderails" dated November 2022, identified the following:	02310		

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	20257	A. BUILDING: _____ B. WING _____	12/14/2022

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02310	Continued From page 59 Zone 1-3 - 3 3/4 inches Zone 4 - 2 3/8 inches On December 13, 2022, at 1:47 p.m. surveyor observed a circular grab bar type consumer siderails. It was a circle on the top attached to a long tube that extended to the floor and a section of the device went in between the mattresses and was secured to the bed on the other side of the bed with a strap. ADON-E stated the measurements on the "residents with siderails" document were inaccurate. She was unaware if the licensee had a copy of the manufacturer's instructions for the siderail and she was unable to confirm that the side rail was installed correctly. She was unaware if the facility had checked the Consumer Product Safety Commission (CSPC) for recalls. ADON-E asked R11 if she had the manufacturer directions, R11 stated she did not and her family member installed it. Review of R11's electronic medical record failed to identify an assessment for siderail use had been completed or that risk versus benefits had been discussed with resident or responsible party. R12 began receiving services under the Assisted Living Facility with Dementia Care (ALFDC) license on August 1, 2021. R12's measurements listed on the "residents with siderails" dated November 2022, identified the following: Zone 1-3 - 3 3/4 inches Zone 4 - 2 3/8 inches On December 13, 2022, at 2:39 p.m. surveyor observed a U-bar shaped grab bar type consumer siderails. It extended between the	02310		

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02310	Continued From page 60	02310		

mattress and box spring of the bed. When pulled out by ADON-E it was noted to be attached to a board with manufacturer instructions for installation on the board. ADON-E after reading the instructions stated it was positioned to high on the bed and should be closer to where the residents waist would be. She adjusted the grab bar to the floor and a section of the device went in between the mattresses and was secured to the bed on the other side of the bed with a strap. ADON-E stated the measurements on the "residents with siderails" document were inaccurate. She was unaware if the facility had checked the CSPC for recalls.

R12's side rail assessment dated December 12, 2022, identified the resident used a half side rail to aide in mobility. The side rail had been installed according to manufacturer directions and risk benefits had been addressed with the resident and responsible party. It did not identify if CSPC had been checked for recalls.

On December 13, 2022, at 1:12 p.m., ADON-E stated that the assessments should be completed in the electronic record and if they were not there, then they had not been completed. ADON-E was unaware who trained DOM-F to assure proper measuring of the siderails for safety according to FDA guidelines. She was unaware if DOM-F's documentation was reviewed by nursing. ADON-E stated the measuring of the siderails to FDA guidelines would be important to have as part of the assessment to prevent injury to the residents.

On December 13, 2022, at 2:08 p.m. DOM-F stated he had been trained by a previous plant operations manager at the adjoined nursing home. When he measured the siderails he did 2

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02310	Continued From page 61 measurements. He measured the gap between the siderail and the mattress of the bed and he measured the distance between the head of the bed to the top of the siderail. The licensee's Side Rail policy dated August 1, 2021, identified "When [the licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [the licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. " "1. Staff from The Residence at North Ridge will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75"." "The resident and, when appropriate. the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record, The education piece is attached to this policy."	02310		

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02310	Continued From page 62 The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails	02310		

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02310	Continued From page 63 includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed as confirmed by onsite observation and document review on December 14, 2022, however, non-compliance remains at level 3, widespread (I). TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *12/14/22*
Time: 12:54:51
Report: 7994221198

Food and Beverage Establishment Inspection Report

Location:
Assisted Living At North Ridge
5500 Boone Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0037615
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7635923000
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

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO APPROVED TEMPERATURE MEASURING DEVICE WAS FOUND ON SITE FOR THE DISHWASHER.

Comply By: 12/14/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM WAS FOUND FOR THIS BUILDING.

Comply By: 12/14/22

4-300 Equipment Numbers and Capacities

4-301.14

MN Rule 4626.0690 Provide ventilation hood systems in sufficient number and capacity to prevent grease or condensation from collecting on walls and ceilings.

DISH AREA FOUND WITH CONDENSATION DAMAGE TO THE CEILING. VENT SYSTEM MAY NEED TO BE ADJUSTED OR SERVICED TO PROVIDE APPROPRIATE VENTILATION.

Comply By: 12/23/22

4-500 Equipment Maintenance and Operation

4-501.11AB

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

UNDER COUNTER COOLER NEAR SODA MACHINE FOUND WITH STANDING WATER. CLEAN UNIT AND ADJUST OR REPAIR TO PREVENT WATER BUILD UP.

Comply By: 12/14/22

6-300 Physical Facility Numbers and Capacities

6-303.11A

MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.

WALK IN FREEZER HAS VERY DIM BULBS MAKING IT DIFFICULT TO CLEAN.

Comply By: 12/23/22

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

THIS WAS AN ANNOUNCED INSPECTION AS PART OF AN HRD SURVEY. I SPOKE WITH THE PERSON IN CHARGE (JAY LEISSO) ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
TOMATEOS 40
VEG 39
MILK 38

POTATOES 138
PORK 154

SANITIZERS:
DISHWASHER 165 F
3 COMP SINK 200 PPM QUAT.

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 7994221198 of 12/14/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

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 #: 7994221198

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1	**Date**	12/14/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:54:51
Legal Authority MN Rules Chapter 4626		**Time Out**	

Assisted Living At North Ridge	**Address** 5500 Boone Avenue North	**City/State** New Hope, MN	**Zip Code** 55428	**Telephone** 7635923000
License/Permit # 0037615	**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
	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		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	X	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	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/14/22

Inspector (Signature) Crystal Elva