

Protecting, Maintaining and Improving the Health of All Minnesotans

# State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306015963M Date Concluded: June 5, 2023

**Compliance #:** HL306014768C

Name, Address, and County of Licensee

Investigated:

Summit Ridge Place 1325 Summit Ave N Sauk Rapids, MN 56379 Benton County

Facility Type: Assisted Living Facility with Evaluator's Name: Barbara Axness, RN

Dementia Care (ALFDC)

Special Investigator

Finding: Substantiated, facility responsibility

#### **Nature of Investigation:**

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

#### Initial Investigation Allegation(s):

The facility neglected the resident when multiple resident-to-resident and resident-to-staff altercations occurred and the facility failed assess and identify new vulnerabilities, susceptibilities to abuse, and/or new risks of harming others. No new interventions were implemented, and existing interventions were not evaluated.

## **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect the resident's health and safety following multiple resident-to-resident and resident-to-staff altercations. The facility was aware the resident exhibited aggressive behaviors and failed to assess, identify, and implement interventions to mitigate future incidents. The facility failed to ensure staff received dementia training and failed to educate staff on managing the resident's behaviors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of facility records and hospital records. At the time of the onsite visit, the investigator observed direct care and medication administration at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included vascular dementia with behavior disturbance (a type of dementia caused by brain damage from impaired blood flow to the brain that causes difficulty with reasoning, planning, judgment, memory, and other thought processes) and depression. The resident did not have a current service plan. The resident did not have an Individual Abuse Prevention Plan and no assessments had been completed.

The resident's record contained 12 incident reports over a period of seven weeks. The incident reports detailed resident-to-resident and resident-to-staff altercations where the resident exhibited behaviors including hitting another resident in the face, pushing another resident causing the other resident to fall on the floor, yelling and swearing at residents and staff, grabbing, hitting, punching, and scratching staff, and pinching a staff member so hard it drew blood. In addition, the incident reports detailed several episodes of sexual behaviors including rubbing another resident's hand on her chest, "rubbing on another male resident and inappropriately touching him", crawling into bed with another resident and "rolling on top of her", and entering other resident rooms after being asked repeatedly to leave. The incident reports did not identify new interventions or attempts to mitigate further occurrences. No assessments were completed after any of the 12 incidents, and no measures were taken to ensure the safety of the resident or other residents living in the facility. An Individual Abuse Prevention Plan was never developed for the resident and staff were not provided further direction, education, or training on how to manage the resident's behavior.

One incident report indicated police were called after the resident became physically violent towards a staff member during a shower. The resident was sent to the hospital after the altercation.

Hospital records indicated the resident was evaluated by psychiatry and medication changes were made. Inpatient psychiatry did not feel the resident was appropriate for admission and recommended the resident return to the facility.

The resident's record contained a partially completed change of condition reassessment, completed remotely by a nurse, after the resident returned from the hospital. The partially completed assessment indicated the resident did not have psychological issues, behaviors, or cognitive issues. The resident's behaviors were not identified on the assessment and the only behavioral symptom noted was "wandering." No new interventions were implemented to ensure the safety of the resident or other residents.

During investigative interviews, multiple unlicensed personnel (ULP) stated the resident had frequent, almost daily, resident-to-resident and resident-to-staff altercations which included physical violence, verbal aggression, and sexual behaviors. Several ULP stated other residents and some staff members were scared of the resident. ULP reported they were directed to call 911 as an intervention and had called 911 on two occasions, including when the resident had COVID-19 and wouldn't stay in her room. One ULP stated police told the staff "there was nothing they could do" because the staff worked on a memory care unit. Another intervention ULP were directed to use was to redirect the resident or call family to come in and sit with the resident. ULP said redirection upset the resident, she would strike out at staff and it wasn't usually successful. Several ULP reported the resident was observed providing oral sex to another resident but "family was notified, and everyone was ok with it" so no new interventions were implemented. However, ULP indicated the sexual behaviors directed towards other residents was not wanted and residents would yell for her to stop. All ULP interviewed stated they were not provided education or training on how to manage the resident's behaviors and did not recall receiving dementia training.

During an interview, a former registered nurse (RN) stated she quit after a few weeks as she was only provided minimal orientation.

During an interview, the current RN stated she did not know why interventions were not implemented or why assessments were not completed for the resident.

During an interview, the regional director of operations (RDO) stated their on-call nurse completed the change of condition assessment and the on-call nurse was not always close to the facility, so it had to be done remotely. The RDO identified challenging behaviors the facility could manage were behaviors that included altercations with staff "to a degree" of hitting, spitting, and verbal behaviors, and felt the facility did a good job of training staff to handle those behaviors. The RDO stated they provided staff with a printed packet with slides about dementia care to take home and review on their own. The RDO wasn't sure how many hours of training were included or how long it took staff to review the printed information. The RDO stated the facility did not receive any resident records with the change of ownership that occurred a few months prior but was not sure why assessments or service plans were not completed after the ownership change. The RDO stated she was not involved with nursing, so she was not aware records were missing so much content.

During an interview, the resident's family member stated the resident's behaviors seemed to accelerate after being confined to her room. The family member said, "9 times out of 10, they were restricting her to her room, and she had enough and struck out." The family member stated the facility didn't offer much for activities and staff did not seem to know how to deal with dementia and behaviors. The family member stated staff didn't know how to provide redirection, so she tried to help them learn different tactics. The family member indicated if the facility staff contacted them, they frequently came over to help with the resident and they were usually able to calm her down by walking around with her. The family member said she was

updated on the resident's sexual behaviors, which were out of character for the resident. The family member indicated they had heard those types of behaviors were common in the type of dementia the resident had but didn't know what other interventions the facility used besides redirection.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility was prepared to manage challenging behaviors and was able to provide one-to-one staffing for special circumstances.

The facility did not have employee files on several employees. Available employee files reviewed, indicated required hours of dementia training were not completed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

#### Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

### Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
- (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, unable Family/Responsible Party interviewed: Yes Alleged Perpetrator interviewed: Not Applicable

## Action taken by facility:

No action taken.

# **Action taken by the Minnesota Department of Health:**

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

CC:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		30601	B. WING		C 03/21/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
SUMMIT R	IDGE PLACE		MIT AVENUE N PIDS, MN 5637		
(V 4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLETE
0 000	Initial Comments		0 000		
	******ATTENTION***** ASSISTED LIVING PE	ROVIDER LICENSING		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to	
	144G.08 to 144G.95,	innesota Statutes, section these correction orders are complaint investigation.		Minnesota State Statutes for Assisted Living License Providers. The assign tag number appears in the far left coluentitled "ID Prefix Tag." The state State number and the corresponding text of	ed ımn :ute
	requires compliance versions of the provided at the statute When a Minnesota St	e number indicated below. atute contains several		state Statute out of compliance is listed the "Summary Statement of Deficience column. This column also includes the findings which are in violation of the statement.	ed in ies" e tate
	items, failure to comply with any of the items will be considered lack of compliance.			requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyor	rs'
	#HL306015963M/#HL			findings is the Time Period for Correct  PLEASE DISREGARD THE HEADING	
	#HL306015363W/#HL			OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF	
	of Health conducted a the above provider, a	the Minnesota Department complaint investigation at and the following correction the time of the complaint		CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE.	IS
	investigation, there we services under the pro- Dementia Care licens	ere 13 residents receiving ovider's Assisted Living with e.		THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION IN VIOLATIONS OF MINNESOTA STATE STATUTES.	
	#HL306015963M/#HL #HL306015964M/#HL	.306015070C, tag 320, 0630, 1060, 1070,		The letter in the left column is used for tracking purposes and reflects the scand level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=C	144G.40 Subd. 2 Unif services	orm checklist disclosure of	0 430		
	(a) All assisted living t	facilities must provide to			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

STATE FORM NQPG11 If continuation sheet 1 of 82

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE. ZIP CODE  SUMMIT RIDGE PLACE  SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379  PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY PILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Department  (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;  (2) a written checklist listing all services permitted under the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and  (3) an oral explanation of the services offered under the contract.  (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.  (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by:  Based on interview and record review, the license failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licenses. This	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  1325 SUMMIT RIDGE PLACE  1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379   [K4) ID PREPIX (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG OR INSCIDENTIFYING INFORMATION)  0 430  Continued From page 1  0 430  Continued From page 1  0 430  Continued From page 1  0 430  (1) a disclosure of the categories of assisted living licenses available and the category of licenses held by the facility; (2) a written checklist listing all services permitted under the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract.  (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.  (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by:  Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately				A. BUILDING		
SUMMIT RIDGE PLACE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  0 430 Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility foliage in the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately			30601	B. WING		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FILL PRECEDED BY FILE PRECEDED BY FILL BY FILL PRECEDED BY FILL PRECEDE	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
X4   D   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED by TUIL) (EACH DEFICIENCY MUST BE PRECEDED by TUIL) (EACH DEFICIENCY MUST BE PRECEDED by TUIL) (EACH DEFICIENCY)    0 430	CHMMIT E	DIDGE DI ACE	1325 SU	MMIT AVENUE NO	ORTH	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  0 430  Continued From page 1  prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services allowed under the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately	30 WINIT F	AIDGE PLACE	SAUK R	APIDS, MN 56379	9	_
prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
(1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately	0 430	Continued From page	· 1	0 430		
had the potential to affect all residents.  This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).  The findings include:  The licensee's Uniform Disclosure of Assisted		prospective residents: (1) a disclosure of the living licenses available license held by the fact (2) a written checklist permitted under the facility assisted living facility assisted living facility services allowed under facility does not provid (3) an oral explanation under the contract. (b) The requirements completed prior to the living contract. (c) The commissioner all interested stakehold checklist disclosure for under paragraph (a).  This MN Requirement by:  Based on interview are licensee failed to ensure disclosure of services reflected services provided the potential to affect health or safety widespread scope (whom it is affect health or safety with it is affect hea	categories of assisted le and the category of cility; listing all services acility's license, identifying offers to provide under the contract, and identifying all er the license that the de; and no f the services offered of paragraph (a) must be execution of the assisted must, in consultation with ders, design the uniform orm for use as provided it is not met as evidenced and record review, the cure the uniform checklist (UDALSA) accurately wided by the licensee. This fect all residents.  in a level one violation (a potential to cause more than the resident and does not and was issued at a men problems are pervasive ic failure that has affected affect a large portion or all			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 2 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	30601	B. WING		C 03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	·	
		MMIT AVENUE N			
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 5637	9		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 430 Continued From page	e 2	0 430			
Living Services and A updated March 24, 20 under Dementia Care indicated that the faci manage challenging I Section 9: Staffing indicate what the spe be. In addition, page there was a registere time.  On March 21, 2023, a personnel (ULP)-J states one or two day needed anything or high call her and she would on March 21, 2023, a assisted living director confirmed the facility Fridays and on call of the RN works at a sistemiles away) on the day and the facility.  On March 21, 2023, a director of operations not sure why the UDA provided one-to-one staffing," accurate on the UDA challenging behaviors manage would be evia	Amenities (UDALSA), last D22, indicated on page 3 and Services Available it was ality was prepared to behaviors. On page 15, dicated the facility was able as staffing for special formments were listed to cial circumstances would 16 of the UDALSA indicated do nurse (RN) on-site full at 9:20 a.m., unlicensed atted the facility RN was only as per week, but if they ad questions, they could do answer.  At 9:30 a.m., licensed for in residence (LALDIR)-B RN was on site Monday and therwise. LALDIR-B stated atter facility (approximately 65 and she is not at the facility. RN is always on call and company but is not full time at 11:15 a.m., regional (RDO)-A stated she was ALSA indicated they				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 3 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30601	B. WING		C <b>03/21/2023</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SUMMIT RIDGE PLACE		MMIT AVENUE NO APIDS, MN 56379			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 430 Continued From page	e 3	0 430			
stated they would be that included altercat hitting, spitting, and we facility had done a go	n was provided.  CORRECTION:				
the requirements for	orting ma g facility must comply with	0 620			
implement a written p	626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.				
by: Based on interview a licensee failed to sub Minnesota Adult Abus (MAARC) for two of the	nd record review, the mit a report timely to the se Reporting Center wo residents (R1, R2) to resident altercations.				
violation that did not safety but had the pore resident's health or some cause serious injury, was issued at a wide problems are pervasi	ve or represent a systemic ed or has potential to affect				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 4 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	TE ZIP CODE		
TV TVILLE OF THOUBER OR COTTELLY		MIT AVENUE N			
SUMMIT RIDGE PLACE		APIDS, MN 5637			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 620 Continued From page	e 4	0 620			
The findings include:					
confusion, disoriental coordination), alcoholdepression.  The resident admitted	ain disorder that can cause ion, and lack of muscle induced dementia, and dementia to the facility on December				
1, 2020, and began receiving services under the current licensee after a change of ownership occurred on June 1, 2022.  The resident's record lacked evidence of a					
current service plan.	Tacked evidence of a				
The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative.					
The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP).					
	August 1, 2022, through the 22, 2022, discharge were				
2022 and included the September 7, 2022, note entered by regist "Resident to staff alter behavior. Per RA [resident asked for ice very dirty with brown	at 8:01 a.m., a behavior tered nurse (RN)-C noted roation with aggressive				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 5 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AT	DDRESS, CITY, STAT	E ZIR CODE		
NAME OF TROVIDER OR OUT LIER		MMIT AVENUE NO			
SUMMIT RIDGE PLACE		APIDS, MN 56379			
(VA) ID SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
0 620 Continued From page	e 5	0 620			
bite staff. Resident go calling, hitting, and poresident was using versident was using versident was using versident was using versident." "I hope you choose (sic) to walk a until resident stopped physicians updated."  -September 8, 2022, note entered by on cast tempting to force fersidents. [R1] started to take items things over, she three staff hitting her in the bent over to pick up to she stood up the resist and struck her in the walked away from the angrily went to her apand locked it. The state the PCP [primary carnorders received to caservices]. Resident we [emergency room] for her behaviorsFamily that the resident does as she is a danger to This was relayed to FLSW [licensed social appropriate placements.]	ot in RA's face, began name ushing. Per RA staff, ery vulgar language such as your cunt." "Go fuck a get raped and like it." Staff away in another direction diffollowing them. Blue stone at 4:01 p.m., a behavior all RN-I noted "Resident was red another resident a Staff asked her to not feed became agitated and off the med cart and push with the banana peel at the face and chest. The staff she banana peel. As soon as dent ran up behind the staff back of the head. Staff the resident and the resident partment, slammed the door aff reported the incident to be physician and verbal and the resident to the physician and verbal and the resident to the physician and verbal and the resident of the incident to the physician and verbal are specificative evaluation of the incident to the community of the rulinerable adults. PCP who is working with ER				
noted entered by RN discharged from the [	e, at 3:00 a.m., a behavior C noted, "Resident [hospital] with diagnosis of SGuardian is requesting				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 6 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				С
	30601	B. WING		03/21/2023
NAME OF DOOMDED OF OURDUIED	OTDEET A			•
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
SUMMIT RIDGE PLACE		MMIT AVENUE NO		
		APIDS, MN 56379		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
0 620 Continued From page	e 6	0 620		
that resident should re and supervised when other residents as gua well-being of staff and community." No new implemented and a M submitted.  -September 22, 2022 note entered by RN-O discharged and transfliving community.  R1s record contained change of condition a 13, 2022, the day she The assessment was indicated R1 had a m swear, bite, and name noted to have behavior others, verbally and p and demonstrates and suspicious behavior. The alert and responsive place, time, and situal memory loss and cour information like recent make safe judgments in social situations. The indicated the resident including verbal and predirection was effect.  The resident's record initiated on September listing interventions for was blank, with no interest in social situations.	emain in her room for meals out in the community with ardian is concerned for the directions within the interventions were AARC report was not.  at 9:05 a.m., a progress indicated the resident ferred to a different senior.  a partially completed seessment from September returned from the hospital. completed remotely and good disorder and will hit, exall. The resident was president was noted to exall. The resident was noted to exe, oriented to person, tion and had no apparent and function appropriately the eassessment further had behavioral symptoms only ical aggression and ive.  contained a care plan er 13, 2022. The section or the resident's behaviors erventions listed. The care ident did not have memory			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 7 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) I AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION (X3		
AND FLAN OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
CHAMIT DIDGE DI ACE	1325 SUN	MIT AVENUE N	ORTH		
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 5637	9		
()(1)	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(7.0)	
	Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
170	,		DEFICIENCY)		
0 620 Continued From page	e 7	0 620			
	nt 8:50 a.m., unlicensed				
	ated she worked frequently				
. , ,	ent had behaviors just				
	ery physically abusive				
	its and staff. ULP-G stated				
	she was aware of was				
	nt or calling her family to				
come in and sit with h	er. ULP-G stated she had				
personally witnessed	R1 push other residents on				
at least two occasions	s. ULP-G stated staff would				
	nselves between R1 and				
	se she would try to push,				
1.	s at them. ULP-G confirmed				
other residents were a					
	joing on for several months.				
	d reported the resident to				
file a MAARC report h	o management but did not				
ille a MAAICO Teport I	ici scii.				
On March 21, 2023, a	nt 9:20 a.m., ULP-J stated				
she would leave work	on a nightly basis with				
bruises from R1 and t	hat R1 would hit other				
residents too. ULP-J s	stated they would try to				
	n and keep other residents				
	weren't able to redirect her				
	s effective. ULP-J stated R1				
	dent and would focus a lot				
	rds the other resident.				
	been having behaviors per 2021. ULP-J stated she				
	vhen another staff member				
	resident bit her breast.				
•	ce were called to help deal				
•	nd the resident had told				
	aff member again, so she				
<b>'</b>	ULP-J stated she was				
	d dementia and cognition				
	she had done video training				
on dementia but did n					
	challenging behaviors.				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 8 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7 (. BOILBII (G		C	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
SUMMIT RIDGE PLACE	1325 SUI	MMIT AVENUE NO	RTH		
JOIMINIT RIDGE PLACE	SAUK RA	APIDS, MN 56379			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETE	
0 620 Continued From pag	e 8	0 620			
assisted living director stated she had worke 2022 to October 202 would manipulate oth high functioning so s LALDIR-B stated R1 towards staff and reshit and yell. LALDIR-R1 or get her to calm triggered her. LALDII the ER after trying to when they told her sloff. R1 threw a remorand said she was go called the police. LAL changed a medication much and she wasn' interventions should.  On March 21, 2023, director of operations not sure if R1 or R2 labuse prevention pla or other assessments change of ownership not get a lot of the reand was not sure who facility staff. RDO-As resident record was resident record was until they were requested. RDO-A confirmed the assessment was not and R2's current concondition assessment by an on call nurse who facility. RDO-A state intervention for behalf					

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 9 of 82

	ENTIFICATION NUMBER:		COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		
	30601	B. WING		C <b>03/21/2023</b>
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF TROVIDER OR OUT LIER		MIT AVENUE N		
SUMMIT RIDGE PLACE		PIDS, MN 5637		
(X4) ID SUMMARY STATEMENT		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
0 620 Continued From page 9		0 620		
staff member's comfort level and if there was a safety issue an intervention used for R1 at the hospital was keeping hel that's what her family had reconfirmed the facility had not a restraint or if other interver been more effective and the implemented it because fames. RDO-A stated she was a reports for both R1 and R2 a history of resident to resident residents. RDO-A stated she had been reported to MAAR done in house investigations investigations were requested stated they did not document and did not have any record investigations entailed. RDO of the incident reports were cout. RDO-A confirmed sever would be reportable but that come from nursing, not the regional director is not reform the regional director is not reform the reduction of the other resident sure they could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sour ethey could keep the from R1 and R2. RDO-A confirmed sourcerns were not confirmed sourcerns were not confirmed sourcerns were not confirmed sourcerns disturbance (a type by brain damage from impair brain that causes difficulty we planning, judgment, memory	de. RDO-A confirmed after her return from in her room as quested. RDO-A tassessed if this was ations would have y had only illy requested they do ware of incident and there was a taltercations for both was not sure if they C but the facility had a Copies of the their investigations is to show what their -A confirmed many only partially filled all of the incidents direction would begional director as a sponsible for the was a mandated were concerns and they were other residents safe affirmed a MAARC residents and their mpleted after R1 and a cular dementia caused ared blood flow to the ith reasoning,			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 10 of 82

STATEMENT OF DEFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMIT RIDGE P	LACE		MMIT AVENUE N APIDS, MN 5637			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	J (X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
0 620 Contin	nued From page	e 10	0 620			
proces	sses) and depre	ession.				
28, 20 curren occurr The re	22, and began It licensee after ed on June 1, 2	to the facility around April receiving services under the a change of ownership 2022.				
The resident's record lacked evidence of any recent assessments.						
The resident's record lacked evidence of a current Individual Abuse Prevention Plan (IAPP).						
Progress notes from August 1, 2022, through the resident's September 20, 2022, discharge were requested.						
Progress notes provided began on September 4, 2022 and included the following notes: -September 4, 2022, at 10:27 a.m., a progress note entered by RN-C indicated there was a "resident to staff altercation-aggressive behavior. Resident pinched staff on arm, hard enough to draw blood. Resident hit, punched, spit, kicked, and threw hard toys and urine bucket at staff. Resident flashing her chest. Resident wishing death on staff as well as saying she was going to kill us. Incident witnessed by all staff and residents. Intervention, resident assisted to her room. No further behavioral concerns noted at this time"						
note e comin offere	ntered by RN-C g out of another d that she was v	at 8:19 a.m., a behavior noted, "resident was r resident's room, staff very mad. RA [resident to redirect resident to her				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 11 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
	30601	B. WING		C <b>03/21/2023</b>
NAME OF PROVIDER OR SUPPL	.IER STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE	
SUMMIT RIDGE PLACE		MMIT AVENUE N		
	SAUK R	APIDS, MN 56379	9	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
0 620 Continued Fro	m page 11	0 620		
	was upset and punched RA in the ere not other witnesses at the time			
	ntained several incident reports ent to resident and resident to staff			
resident alterc	at 3:30 p.m., a resident to ation was reported by ULP after R2			
red marks. No	hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC.			
altercation was	at 7:40 p.m., a resident to resident reported by ULP after R2 was ing another resident's hand on her			
chest. The oth	er resident was noted to be pulling R2 to stop. R2 hit the resident in			
the back. No n	ew interventions were noted and as not reported to MAARC.			
-July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing				
on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff				
punching staff	became very angry and began  No new interventions were noted  nt was not reported to MAARC.			
staff altercation was observed "being rude, ye	throughout the day, a resident to was reported by ULP after R2 walking up and down the hallways elling, calling names, in other ns, ripped [staff member's] nail off,			
	ushed [staff member] down the			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 12 of 82

		(X3) DATE SURVEY COMPLETED
A. BUILDING:		
B. WING		03/21/2023
RESS, CITY, STAT	E, ZIP CODE	
MIT AVENUE NO	ORTH	
PIDS, MN 56379		
ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
0 620		
١	A. BUILDING:  B. WING  ORESS, CITY, STATE  WIT AVENUE NO  PIDS, MN 56379  ID  PREFIX  TAG	A. BUILDING:  B. WING  DRESS, CITY, STATE, ZIP CODE  WIT AVENUE NORTH  PIDS, MN 56379  ID  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 13 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>,</b> ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, Boile Bii (o		C	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CLINANAIT I		1325 SU	MMIT AVENUE N	ORTH		
SUMMIT	RIDGE PLACE	SAUK RA	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 620	Continued From page	13	0 620			
	resident and resident reported by ULP after resident's room and be attempting to redirect swearing and grabbed and would not let go. noted and the inciden MAARC.  -September 4, 2022, was reported by ULP member on the arm a september 5, 2022, was reported by ULP another resident's room.	roke her TV. Staff reported R2 but she kept yelling and the staff member's wrist No new interventions were twas not reported to a resident to staff altercation after R2 pinched a staff nd drew blood.				
	showerwhen I went she only allowed me to down before stepping took them off in the she wash her up so we fin scream and pinching dress her or dry her or bathroom naked, wet, to rip things off the wash out off (sic) the bathrohitting and scratching called and both said to didn't know what we we cops were called. [R2] both. [R2] walked out shirt and wet socks or	ndicated on September 7, nto the bathroom for a to help her with her pants, o pulled (sic) them halfway into the shower. She then nower. She wouldn't let me				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 14 of 82

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STAT	TE ZIR CODE		
NAME OF FROVIDER OR SUPPLIER					
SUMMIT RIDGE PLACE		MIT AVENUE NO APIDS, MN 56379			
OLIMAN DV CT				1 0.5	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE	
0 620 Continued From page	· 14	0 620			
calmly, moving quickleget herself dress (sic) with a towel so we comput everything she consumated a partially of condition assessment and had nothing note behaviors, or cognitive the only issue checked The resident was not behaviors. No new interventions were and the place to ensure the set R2.  On March 20, 2023, and R2 could be in a really consumer and the set of the se	from the hospital on The resident's record completed change of dated September 13, it was completed remotely d for psychological issues, e issues. Wandering was d for behavioral symptoms. noted to have any other erventions were put in afety of other residents or  at 9:00 a.m., ULP-G stated by great mood then with the				
flip of a switch, she'd "I can 100% say yes, scared of her. We got	be in a rage. ULP-G stated, the other residents were to the point we had to put				
other resident's rooms a few times R2 was c male resident's room	she couldn't get into the s." ULP-G stated there were aught going in to another and providing oral sex to				
MAARC and no other place. ULP-G stated f	it" so it was not reported to interventions were put in R2 would try sticking her le resident's shorts and				
intervene and redirect	when they saw it				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 15 of 82

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3)		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STDEET AF	DDRESS, CITY, STAT	E ZID CODE		
NAME OF FROVIDER OR SUFFLIER					
SUMMIT RIDGE PLACE		MMIT AVENUE NO APIDS, MN 56379			
CLIMMADY CT					
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 620 Continued From page	e 15	0 620			
bed with a different more kiss him and that the notified but the residence of the notified has been also behaviors were made residence of the notified of the notified has been also behaviors were too vispolice.	ated R2 would try to climb in hale resident, hold his hand, he resident's family was ent was his own person so swere done. ULP-G stated working with R2 and felt like er residents safe either. A was notified of all those is not sure if any MAARC egarding R2's behaviors. Sy interventions they used or calling the resident's list with her, if the resident's colent, they would call the				
both R1 and R2 would with both residents are interventions used income to relax, redired come in and sit with had to be called after room after being diage ULP-F stated police of "there was nothing the worked in a memory didn't get any other gother nurse on how to hallenging behaviors any training on MAAF she didn't feel like she the end because it was	at 9:20 a.m., ULP-F stated d have physical altercations and staff. ULP-F stated cluded sending her to her sting, and calling family to her. ULP-F stated the police R2 wouldn't stay in her mosed with COVID-19. Stated, ey could do because I care unit." ULP-F stated she uidance or direction from handle either resident's and could not recall getting RC reporting. ULP-F stated e could care for R2 towards as too dangerous and she arms from being scratched				
R2's behaviors deper she'd be great other t	at 9:30 a.m., ULP-J stated nded on the day, sometimes times everything was wrong.  Ild hit and pinch staff and				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 16 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION I	, ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			С	
30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE N	IORTH		
	SAUK RAPIDS, MN 5637	79		
(X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED  TAG  REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
0 620 Continued From page 16	0 620			
would go after other residents at times. stated R2 had some other episodes of inappropriate behavior towards other reand that they had caught her giving oral another resident once. ULP-J stated R2 to touch several other male residents ar would tell her no and to stop but she wo they were in wheelchairs so not able to ULP-J was not sure if any of the inciden been reported to MAARC but thought si guardian was ok with it, it was fine. ULP the police had to be called on R2 after s and spit on staff and she did the same to responding officers. ULP-J stated when and R2 returned from the ER, they did not any new interventions or new direction of manage either resident's behaviors. ULI she knew R2 had dementia but didn't kn anything else on what she had.  On March 21, 2023, at 10:45 a.m., LALI stated R2 would go from 0 to 60, she'd leaughing then smack you in the face. LA stated if R2 had bad behaviors, they'd to redirect or try activities like coloring or more it wasn't always effective. LALDIR-B stated was not sure if any MAARC reports had submitted for any of the resident to resident to residents plan of care after they returned the hospital.  The licensee's 2.49 Vulnerable Adult Maltreatment - Prevention & Reporting and the coloring of the resident to residents plan of care after they returned the hospital.  The licensee's 2.49 Vulnerable Adult Maltreatment - Prevention & Reporting and the coloring of the resident to residents plan of care after they returned the hospital.	sidents sex to would try d they ouldn't and get away. Its had Ince R2's -J stated She hit To the To			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 17 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		С
		30601	D. VVIIVO		03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
SUMMIT F	RIDGE PLACE		MMIT AVENUE NO		
	OLIMANA DV. OTA		APIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE
0 620	Continued From page	17	0 620		
	incident appears to be or financial exploitation. Services or Communitimmediately make an [common entry point].  No further information	oral report to the CEP			
	` '	rting ma evelop and implement an	0 630		
	person's risk of abusing and statements of the taken to minimize the	plan shall contain an or assessment of the to abuse by another ther vulnerable adults; the ng other vulnerable adults; specific measures to be risk of abuse to that person adults. For purposes of the			
	by: Based on interview are licensee failed to ensure prevention plan (IAPF) address resident vulninterventions for behavior residents (R1, R2), which is to resident altercations. In additional tercations, and address the IAPF address residents and address residents (R1, R2), which is to resident altercations. In additional tercations, and address residents (R1, R2), which is the resident altercations. In additional tercations, and address resident vulning to the resident altercation altercations.	ure an individual abuse  b) was developed to erability with specific viors for two of two had a history of resident			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 18 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF D		OTDEET A			•	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SUMMIT F	RIDGE PLACE		MMIT AVENUE N			
			APIDS, MN 5637			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE	
0 630	Continued From page	· 18	0 630			
	of inappropriately touch other residents in the dementia care facility.  This practice resulted violation that harmed safety, not including some or death, or a violation lead to serious injury, was issued at a patter limited number of resident a limited number.	in a level three violation (a a resident's health or erious injury, impairment, a that has the potential to impairment, or death), and on scope (when more than a dents are affected, more of staff are involved, or the direpeatedly; but is not				
	The findings include:	<b>,</b> -				
	R1 and R2 both had a behaviors, including vaggression towards of the RN failed to asserbehaviors, and failed de-escalate the reside Both residents continuphysical behaviors that residents being hit, puaddition, the RN failed behaviors displayed behavioral symptoms condition and failed to behavioral symptoms condition and failed to	taff and other residents. ss the behaviors, cause for to identify interventions to ents' displayed behaviors. ued to display verbal and at resulted in other ushed, and yelled at. In d to assess sexual by R2, resulting in other inappropriately touched RN also failed to ensure ssessments were I and R2 after a return from ately reflected their current				
	R1 R1's diagnoses includ	led Wernicke's				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 19 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SUMMIT F	RIDGE PLACE		MMIT AVENUE NO APIDS, MN 56379			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	BE COMPLETE	
0 630	Continued From page	19	0 630			
	confusion, disorientation coordination), alcoholololologenession.  The resident admitted 1, 2020, and began residential confusion.	ain disorder that can cause on, and lack of muscle induced dementia, and to the facility on December eceiving services under the a change of ownership 2022.				
	The resident's record lacked evidence of a current service plan.					
The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative.						
	The resident's record current Individual Abu	lacked evidence of a se Prevention Plan (IAPP).				
	resident's September requested. Progress requested. Progress respectively. September 7, 2022 are notes: -September 7, 2022, anote entered by registed behavior. Per RA [restresident asked for ice very dirty with brown wher a clean cup to fill a bite staff. Resident go calling, hitting, and puresident was using very dirty with brown where a clean cup to fill a bite staff. Resident go calling, hitting, and puresident was using very yourself." "I hope you	RAs saw cup she had was water, so staff offered to get and resident attempted to the in RA's face, began name shing. Per RA staff, ry vulgar language such as				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 20 of 82

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		С	
		30601	B. WING		03/21/2023	
NAME OF PROVIDER OR	SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	_	1325 SUN	MIT AVENUE N	ORTH		
SUMMIT RIDGE PLAC	E	SAUK RA	PIDS, MN 5637	9		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(7.0)	
		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
17.0				DEFICIENCY)		
0 630 Continue	d From page	e 20	0 630			
	s updated."	I following them. Blue stone				
' '	•	at 4:01 p.m., a behavior				
		all RN-I noted "Resident was				
	•	ed another resident a				
' '	-	Staff asked her to not feed				
other resid	dents. [R1]	became agitated and				
started to	take items	off the med cart and push				
things over	er, she threv	v the banana peel at the				
	•	face and chest. The staff				
	•	he banana peel. As soon as				
	•	dent ran up behind the staff				
		back of the head. Staff				
	•	e resident and the resident				
	•	partment, slammed the door aff reported the incident to				
		e physician] and verbal				
-		Il EMS [emergency medical				
		as transported to ER				
-		psychiatric evaluation of				
her behav	riorsFamil	ies (sic) current wishes are				
that the re	esident does	sn't return to the community				
as she is	a danger to	other vulnerable adults.				
	•	PCP who is working with ER				
-		worker] to find more				
' ' '	•	nt. No new interventions				
submitted		nd a MAARC report was not				
		, at 3:00 a.m., a behavior				
	•	-C noted, "Resident				
	•	hospital] with diagnosis of				
	-	Guardian is requesting				
		emain in her room for meals				
and super	vised when	out in the community with				
other resid	dents as gu	ardian is concerned for the				
well-being	of staff and	d residents within the				
	•	interventions were				
		1AARC report was not				
submitted		-1 0.0F				
-Septemb	er 22, 2022	, at 9:05 a.m., a progress				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 21 of 82

STATEMENT OF		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		30601	B. WING		03/21/2023	
	#DED OD OU DD 150	0.7.0.		TE 715 0055		
NAME OF PROV	IDER OR SUPPLIER		DRESS, CITY, STA			
SUMMIT RID	GE PLACE		MIT AVENUE N			
		SAUK RA	APIDS, MN 5637	9		
(X4) ID		TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(7.0)	
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
0.630 C	ontinued From page	21	0 630			
	•	indicated the resident				
		erred to a different senior				
liv	ing community.					
	bo focility foiled to de	avolon on IADD offer only of				
	ne racility railed to de le above documente	evelop an IAPP after any of				
Li i	le above documente	a incidents ocurred.				
	he resident's record	contained a partially				
		condition assessment from				
		the day she returned from				
	•	essment was completed				
	•	d R1 had a mood disorder				
ar	nd will hit, swear, bite	e, and name call. The				
re	sident was noted to	have behaviors with a				
hi	story of harming oth	ers, verbally and physically				
ak	ousive to staff, and d	lemonstrates				
ar	nxious/paranoid or s	uspicious behavior. The				
		be alert and responsive,				
	• • •	ace, time, and situation and				
	• •	ory loss and could recall or				
		recent events and was				
	•	gments and function				
·	opropriately in social	dicated the resident had				
		including verbal and				
	nysical aggression a	•				
•	,	ailed to develop an IAPP				
	ter the resident retur	-				
TI	he resident's record	contained a care plan				
in	itiated on Septembe	r 13, 2022. The section				
lis	sting interventions fo	r the resident's behaviors				
W	as blank with no inte	rventions listed. The care				
		dent did not have memory				
lo	ss and could recall a	and retain information.				
	h = ===!=!===# <b>^</b> '	- l				
	•	nber 2022 medication				
	dministration record	•				
		for QUEtiapine Fumarate				
(a	ın anupsychotic med	lication to treat mood				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 22 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SUMMIT RIDGE PLACE		MMIT AVENUE NO			
		APIDS, MN 56379			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE	
0 630 Continued From page	e 22	0 630			
conditions) 0.5 tablets as needed for agitatic used at any point in SAugust 2022 was required. On March 20, 2023, a personnel (ULP)-G state with R1 and the reside about daily and was attowards other resider the only interventions redirecting the reside come in and sit with the personally witnessed at least two occasions often have to put there other residents because punch, or throw things other residents were behaviors had been gouldly the state of the st	s by mouth every 12 hours on. The medication was not september. A MAR for uested, but not provided.  at 8:50 a.m., unlicensed ated she worked frequently ent had behaviors just very physically abusive ats and staff. ULP-G stated she was aware of was not or calling her family to her. ULP-G stated she had R1 push other residents on s. ULP-G stated staff would asselves between R1 and her going on for several months. It is at them. ULP-G confirmed afraid of R1 and her going on for several months. It is a the resident to the management but did not her self.  at 9:20 a.m., ULP-J stated at an an ightly basis with that R1 would hit other ULP-J stated they would try				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 23 of 82

STATEMENT OF DEFICIENCIE		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUF	PPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
			MMIT AVENUE N	•		
SUMMIT RIDGE PLACE			APIDS, MN 5637			
(X4) ID SU	JMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX (EACH	DEFICIENC'	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE COMPLETE	
0 630 Continued F	rom page	23	0 630			
so she was aware to cognition is so video training on moderations.  On March 2 assisted living stated she had to October 2 manipulate of functioning stated R1 was residents and LALDIR-B sinher to calmon her. LALDIR after trying to they told here R1 threw are said she was the police. Lachanged a moderation and slinterventions.  R2 R2's diagnost behavior discontinuation of the police of the police of the police of the police of the police. Lachanged and much and slinterventions.	taken to the reside sues. ULP gon dem nanging 1, 2023, and gon dem nanging 1, 2023, and gon dem nange the substant of the could be a substant of the could b	he ER. ULP-J stated she nt had dementia and r-J stated she had done entia but did not get any difficult or challenging  at 10:40 a.m., licensed r in residence (LALDIR)-B d as a ULP from February DIR-B stated R1 would dents and was more high ew who to target. LALDIR-B ggressive towards staff and binch and hit and yell. r'd try to redirect R1 or get If figure out what triggered R1 was sent to the ER other resident and when dn't do that, it set her off. a staff members head and b kill herself so they called stated she knew they n in the ER but it didn't do sure what other be used.  ded vascular dementia with (a type of dementia caused in impaired blood flow to the culty with reasoning, nemory, and other thought	0 630			
28, 2022, ar	t admitted nd began see after	to the facility around April receiving services under the a change of ownership				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 24 of 82

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BOILDING.		С	
		30601	B. WING	_	03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SHMMITE	RIDGE PLACE	1325 SU	MMIT AVENUE NO	DRTH		
30 WIWIT N	AIDGL PLACE	SAUK R	APIDS, MN 56379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
0 630	Continued From page	24	0 630			
	The resident's record current service plan.	lacked evidence of a				
	The resident's record recent assessments.	lacked evidence of any				
	The resident's record current Individual Abu	lacked evidence of a se Prevention Plan (IAPP).				
	resident's September requested. Progress respectively 2022 are notes: -September 4, 2022, anote entered by RN-Courseident to staff altered Resident pinched staff draw blood. Resident and threw hard toys and Resident flashing her death on staff as well kill us. Incident witness residents. Intervention room. No further behalt this time" -September 7, 2022, anote entered by RN-Country out of another offered that she was wassistant] attempted to room, resident was up	n, resident assisted to her avioral concerns noted at at 8:19 a.m., a behavior				
	detailing resident to real altercations. -July 20, 2022, at 3:30	several incident reports esident and resident to staff  p.m., a resident to as reported by ULP after R2				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 25 of 82

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  325 SUMMIT AVENUE NORTH  SAUK RAPIDS, MIN 55379  PROVIDER SHAND OF CORRECTION  (EACH DEPRICENCY MUST BE RECEDED BY PLUL  (EACH DEPRICENCY MUST BE RECEDED BY PLUL  (EACH CORRECTIVE ACTION SHOULD BE  CROSS REPERENCIATION SHOULD BE  CROSS REPERENCIATIO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY STATE, ZIP CODE  1325 SUMMIT RIDGE PLACE  SUMMIT RIDGE PLACE  SAUK RAPIDS, MN 66379  PROVIDERS HAN OF CORRECTION  (A9) PRETRY (EACH OPERCIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 630  Continued From page 25  hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC.  -July 20, 2022, at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another malie resident mappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC.  -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped (staff member) and off, choked, and pushed [staff member] nai off, choked, and pushed [staff member] nai off, choked, and pushed [staff member] and off.			A. BOILBING.		
SUMMIT RIDGE PLACE    SUMMARY STATEMENT OF DEPICIENCIES   SUMMARY STATEMENT OF DEPICIENCY   SUMMARY STATEMENT OF DEPICE OF DEPICE ON THE APPROPRIATE DATE   DEPICIENCY   SUMMARY STATEMENT OF DEPICE OF DEPICE ON THE APPROPRIATE DATE   DEPICIENCY   SUMMARY STATEMENT OF DEPICE OF DEPICE ON THE APPROPRIATE DATE   DEPICIENCY   SUMMARY STATEMENT OF DEPICE OF DEPICE ON THE APPROPRIATE DATE   CROSS-REFERENCED TO NETHER DATE   CROSS-REFERENCED TO NETHER DATE   DATE OF DEPICE ON THE APPROPRIATE   DATE OF DATE OF DATE OF DATE   DATE OF DATE O		30601	B. WING	_	
SAUK RAPIDS, MN 66379  (X4) ID PREPIX ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D	NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
SAUK RAPIDS, MN 56379  (X4) ID PREPIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D		1325 SUI	MMIT AVENUE NO	RTH	
PREFIX TAG PROPERTY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O 630  Continued From page 25  hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC.  -July 20, 2022, at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC.  -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff mem	SUMMIT RIDGE PLACE				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  0 630  Continued From page 25  hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC.  -July 20, 2022, at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC.  -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, fipped [staff member's] nail off, choked, and pushed [	(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
hit another resident twice in the face, leaving little red marks. No new interventions were noted and the incident was not reported to MAARC.  -July 20, 2022, at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC.  -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member] down the hallway."  -August 12, 2022, at 2:17 p.m., the resident was	PREFIX (EACH DEFICIENC)		PREFIX	CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
red marks. No new interventions were noted and the incident was not reported to MAARC.  -July 20, 2022, at 7:40 p.m., a resident to resident altercation was reported by ULP after R2 was observed rubbing another resident's hand on her chest. The other resident was noted to be pulling away and told R2 to stop. R2 hit the resident in the back. No new interventions were noted and the incident was not reported to MAARC.  -July 21, 2022, at 6:00 p.m., a resident to resident and resident to staff altercation were reported by ULP after R2 was observed rubbing on another male resident and inappropriately touching him. The male resident was pushing R2 away and told her to go away. When staff intervened, R2 became very angry and began punching staff. No new interventions were noted and the incident was not reported to MAARC.  -July 25, 2022, throughout the day, a resident to staff altercation was reported by ULP after R2 was observed walking up and down the hallways  "being rude, yelling, calling names, in other resident's rooms, ripped [staff member's] nail off, choked, and pushed [staff member's] nail off, choked, and	0 630 Continued From page	25	0 630		
-August 15, 2022, at 8:00 p.m., a resident to resident altercation was reported by ULP after R2 was observed to be crawling in to bed with another resident and "roll on top of her." When ULP attempted to redirect R2, she punched staff with a closed fist to the face. A note was entered by the RN on August 16, 2022, indicating "no additional interventions needed." No new interventions were noted and the incident was not reported to MAARC.  -August 16, 2022, at 9:15 p.m., a resident to	hit another resident to red marks. No new in the incident was not reduced and resident was reported to the back. The other resident away and told R2 to so the back. No new interesident and resident reported by ULP after on another male resident and told her to go intervened, R2 became punching staff. No new and the incident was resident's rooms, ripped choked, and pushed hallway."  -August 12, 2022, at a resident altercation was observed to have had a chaugust 15, 2022, at a resident altercation was observed to be continued and the resident and ull attempted to red with a closed fist to the by the RN on August additional intervention interventions were not reported to MAAF.	vice in the face, leaving little terventions were noted and eported to MAARC.  In p.m., a resident to resident ted by ULP after R2 was other resident's hand on her dent was noted to be pulling stop. R2 hit the resident in erventions were noted and eported to MAARC.  In p.m., a resident to to staff altercation were R2 was observed rubbing dent and inappropriately alteresident was pushing R2 go away. When staff he very angry and began we interventions were noted not reported to MAARC. Shout the day, a resident to eported by ULP after R2 gup and down the hallways alling names, in other ed [staff member] down the staff member with to as reported by ULP after R2 rawling in to bed with "roll on top of her." When irect R2, she punched staff e face. A note was entered 16, 2022, indicating "no as needed." No new sted and the incident was esc.			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 26 of 82

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. BOILDING.		
		30601	B. WING		03/21/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			MMIT AVENUE N		
SUMMIT R	IDGE PLACE		APIDS, MN 5637		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
0 630	Continued From page	26	0 630		
	went in another reside	ent's room and pushed her,			
	causing the resident to	o fall back on the floor. The			
	other resident was no	ted to have a small scratch			
	on her forearm after the	ne altercation. No new			
	interventions were not	ted and the incident was			
	not reported to MAAR	C.			
	, ,	m 3:00 p.m. to 6:00 p.m.,			
	•	ident report after R2 would			
	•	esidents rooms, even after			
	•	R2 was noted to keep			
	•	nterventions were noted and			
	the incident was not re	•			
	, ,	5:30 p.m., a resident to as reported by ULP after R2			
		who was eating dinner and			
	•	ne. The other resident			
		d R2 hit the resident. Staff			
		[resident] to walk away and			
	R2 keeped (sic) going				
	interventions were not	ted and the incident was			
	not reported to MAAR	C.			
	-August 27, 2022, at 7	7:45 p.m., a resident to			
	resident and resident	to staff altercation was			
	reported by ULP after				
		roke her TV. Staff reported			
	, •	R2 but she kept yelling and			
	•	the staff member's wrist			
	•	No new interventions were			
	noted and the incident MAARC.	t was not reported to			
		a resident to staff altercation			
	•	after R2 pinched a staff			
	member on the arm a	•			
		a resident to staff altercation			
	was reported by ULP				
	•	m and was very mad. ULP			
		but R2 punched her in the			
	chest.				
	TI 6 6				
	I he facility failed to de	evelop an IAPP after any of			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 27 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
					С	
		30601	B. WING		03/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SHMMIT	RIDGE PLACE	1325 SUM	IMIT AVENUE N	ORTH		
JOIVIIVII I	NDOL I LAGE	SAUK RA	PIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
0 630	Continued From page	27	0 630			
	the documented incide	ents ocurred.				
	showerwhen I went she only allowed me to down before stepping took them off in the showash her up so we fin scream and pinching dress her or dry her or bathroom naked, wet, to rip things off the war out off (sic) the bathrohitting and scratching called and both said the didn't know what we were called. [R2] both. [R2] walked out shirt and wet socks or other residents in the interventions, ULP-G calmly, moving quickly get herself dress (sic) with a towel so we concave out of her reach called sisters (both). The resident returned september 13, 2022. The resident returned september 13, 2022. Contained a partially condition assessment and had nothing noted.	indicated on September 7, into the bathroom for a to help her with her pants, o pulled (sic) them halfway into the shower. She then hower. She wouldn't let me ished while she was me. She wouldn't let me ished while she was me. She wouldn't let me if. Was walking around the throwing things and trying will. When I wouldn't let her form naked she started me. Sister's (sic) were both hey couldn't come or they want her to do about it.  If spit on one cop and hit of the bathroom with only a many so we had to shut all living room." For immediate moted she tried talking moving slowly, letting her moted she tried talking moving slowly, letting her moted she tried talking with the bathroom. I will break, throw, or pull on a ligave her space. Then we noted and the incident AARC. The resident was woroom.  If on the hospital on the resident's record completed change of				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 28 of 82

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:COMPLI	
		20604	B. WING		C 02/24/2022
		30601			03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		1325 SUI	MMIT AVENUE N	ORTH	
SUMMIT F	RIDGE PLACE	SAUK RA	APIDS, MN 5637	9	
( <b>V 4) 1D</b>	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(7.0)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
0 630	Continued From page	28	0 630		
	_	d for behavioral symptoms.			
		noted to have any other			
		erventions were put in			
	'	afety of other residents or			
		to develop an IAPP after			
	the resident returned	to the facility.			
		it 9:00 a.m., ULP-G stated			
	•	y great mood then with the			
	· ·	be in a rage. ULP-G stated,			
		the other residents were			
		to the point we had to put			
		she couldn't get into the			
		s." ULP-G stated there were			
		aught going in to another			
		and providing oral sex to			
	that resident but "fam	•			
		it" so it was not reported to			
		interventions were put in			
	1 - T	R2 would try sticking her			
	•	le resident's shorts and			
	"he'd slap her away" a	_			
	intervene and redirect	-			
		ated R2 would try to climb in			
		ale resident, hold his hand,			
		ne resident's family was			
		nt was his own person so			
		were done. ULP-G stated			
		vorking with R2 and felt like			
	•	er residents safe either.			
		was notified of all those			
		s not sure if any MAARC			
	· •	garding R2's behaviors.			
	_	/ interventions they used			
		r calling the resident's			
		sit with her, if the resident's			
		olent, they would call the			
	police.				
	On March 20 2000	+ 0.20 a m			
	On Warch 20, 2023, a	it 9:20 a.m., ULP-F stated			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 29 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING:		
	30601	B. WING	_	C 03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SUI	MMIT AVENUE NO	RTH	
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379		
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
0 630 Continued From p	age 29	0 630		
with both residents interventions used room to relax, redictions and sit with had to be called at room after being of ULP-F stated policy. There was nothing worked in a memoral didn't get any other the nurse on how challenging behave any training on Marsh and hit by R2.	and staff. ULP-F stated included sending her to her recting, and calling family to the her. ULP-F stated the police ter R2 wouldn't stay in her lagnosed with COVID-19. The didn't come as they stated, they could do because I ry care unit." ULP-F stated she reguldance or direction from to handle either resident's fors and could not recall getting wARC reporting. ULP-F stated she could care for R2 towards was too dangerous and she her arms from being scratched she at 9:30 a.m., ULP-J stated bended on the day, sometimes			
ULP-J stated R2 would go after oth stated R2 had son inappropriate behavior and that they had	er times everything was wrong.  Yould hit and pinch staff and er residents at times. ULP-J ne other episodes of evior towards other residents caught her giving oral sex to			
to touch several of would tell her no a they were in wheel ULP-J was not subseen reported to been reported to be guardian was ok with a police had to be and spit on staff a responding officer and R2 returned from the police had to be a polic	her male residents and they nd to stop but she wouldn't and chairs so not able to get away. e if any of the incidents had MAARC but thought since R2's with it, it was fine. ULP-J stated e called on R2 after she hit and she did the same to the s. ULP-J stated when both R1 om the ER, they did not get ons or new direction on how to ident's behaviors. ULP-J stated			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 30 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BOILDING.		
	30601	B. WING		C 03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SU	MMIT AVENUE NO	RTH	
SUMMIT RIDGE PLACE	SAUK R	APIDS, MN 56379		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
0 630 Continued From page	e 30	0 630		
she knew R2 had der anything else on wha	mentia but didn't know t she had.			
stated R2 would go for laughing then smack stated if R2 had bad redirect or try activities it wasn't always effect was not sure if any M submitted for any of the altercations. LALDIR- of any new interventions of any new interventions the hospital.	behaviors, they'd try to selike coloring or music but tive. LALDIR-B stated she AARC reports had been he resident to resident. B stated she was not aware ons or changes to either after they returned from			
director of operations not sure if R1 or R2 habuse prevention plator other assessments change of ownership not get a lot of the reand was not sure what facility staff. RDO-Astresident record was runtil they were reque RDO-A confirmed the assessment was not and R2's current concondition assessment by an on call nurse was facility. RDO-A state intervention for behavious tituation was different staff member's comformed if there was a satisfactor used the hospital was keep	at 11:15 a.m., regional (RDO)-A stated she was lad service plans, individual lans, behavioral assessments, s. RDO-A stated with the lon June 1, 2022, they did cords from the prior owner lat had been completed by latted she did not realize the missing those documents latted by the investigator. It is september 13, 2022, lan accurate reflection of R1 lattion as both the change in latts were completed remotely latho was not close to the latting the police as an lattic level with the behavior latting the police as an lattic level with the behavior latting the police as an lattic level with the behavior latting the return from			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 31 of 82

S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURV COMPLETE	
				С	
	30601	B. WING		03/21/2	2023
PLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	1325 SUM	MIT AVENUE N	ORTH		
	SAUK RA	PIDS, MN 5637	9		
DEFICIENC'	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE C	(X5) COMPLETE DATE
rom page	e 31	0 630			
e facility if other i ffective a lit becau tated she other to re ident to re corted to re investi s were re lid not do re any s entailed ortable b ursing, n director is confirmed ortable b ursing R1 the other cold to re confirmed ortable b ursing R1 the other confirmed ortable b	had not assessed if this was interventions would have and they had only see family requested they do a was aware of incident and R2 and there was a resident altercations for both ted she was not sure if they MAARC but the facility had gations. Copies of the equested however RDO-A ocument their investigations records to show what their d. RDO-A confirmed many awere only partially filled diseveral of the incidents out that direction would not the regional director as an not responsible for remed she was a mandated and there were concerns and R2 due to safety residents and they were seep the other residents safe D-A confirmed a MAARC to other residents and their not completed after R1 and facility.  Individual Abuse Prevention gust 1, 2021, indicated the and implement an ention plan for each esidents in an assisted by considered vulnerable.				
D FOR (	CORRECTION: Seven (7)				
	rom page e factive a distribute a factive a distribute a factive a distribute a factive a factiv	30601 PLIER STREET AD 1325 SUM	A BUILDING:  30601  PLIER  STREET ADDRESS, CITY, STA  1325 SUMMIT AVENUE N SAUK RAPIDS, MN 5637  MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)  Tom page 31  of active and they had only if the because family requested they do tated she was aware of incident both R1 and R2 and there was a sident to resident altercations for both DO-A stated she was not sure if they borded to MAARC but the facility had se investigations. Copies of the s were requested however RDO-A did not document their investigations have any records to show what their s entailed. RDO-A confirmed many not reports were only partially filled confirmed several of the incidents bortable but that direction would ursing, not the regional director as director is not responsible for D-A confirmed she was a mandated O-A stated there were concerns itting R1 and R2 due to safety the other residents and they were of could keep the other residents safe R2. RDO-A confirmed a MAARC half of the other residents and their rns were not completed after R1 and and to the facility.  A BUILDING:  A BUILD	PLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379  MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LISC IDENTIFYING INFORMATION)  TOM page 31  e facility had not assessed if this was if other interventions would have frective and they had only but he lated she was aware of incident shr R1 and R2 and there was a sident to resident altercations for both DO-A stated she was not sure if they ported to MAARC but the facility had be investigations. Copies of the se ware requested however RDO-A did not document their investigations have any records to show what their is entailed. RD-A confirmed many not reports were only partially filled confirmed several of the incidents bordable but that direction would urising, not the regional director as director is not responsible for D-A confirmed a MAARC had be investigations and they were could keep the other residents safe R2. RDO-A confirmed a MAARC had be an additional to the facility.  See 6.5 Individual Abuse Prevention dated August 1, 2021, indicated the develop and implement an use prevention plan for each dult. All residents in an assisted egorically considered vulnerable formation provided.	PLIER  STREET ADDRESS, CITY, STATE ZIP CODE  1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379  MMARY STATEMENT OF DEPICIENCIES  DEPICIENCY MUST BE PRECEDED BY FULL TAGY OR LSC IDENTIFYING INFORMATION)  TOT page 31  or facility had not assessed if this was if other interventions would have ffective and they had only it because family requested they do tated she was aware of incident other interventions for both DO-A stated she was not sure if they control to MARC but the facility had be investigations. Copies of the server equested however RDO-A did not document their investigations lave any records to show what their sentialer. ADO-A confirmed many it reports were only partially filled confirmed several of the incidents ontable but that direction would ursing, not the regional director as director is not responsible for D-A confirmed she was a mandated O-A stated there were concerns itting R1 and R2 due to safety the other residents and their ms were not completed after R1 and do to the facility.  10 50.05 Individual Abuse Prevention dated August 1, 2021, indicated the ldevelop and implement an use prevention plan for each dult. All residents in an assisted egorically considered vulnerable formation provided.

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 32 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 501251110.		С
		30601	B. WING		03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE. ZIP CODE	
			MMIT AVENUE N		
SUMMIT F	RIDGE PLACE		APIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
0 630	Continued From page	32	0 630		
	days.				
01060 SS=F	144G.52 Subd. 9 Eme	ergency relocation	01060		
	facility in an emergent resident's urgent med risk the resident poses another facility resider. An emergency relocated (b) In the event of an facility must provide a contains, at a minimum (1) the reason for the (2) the name and conflocation to which the rand any new service (3) contact information Ombudsman for Long of Ombudsman for Long of Ombudsman for Medical Disable (4) if known and applied or range of dates with expected to return to that a return date is not (5) a statement that, if provide housing or seresident has the right 144G.54. The facility information for the against submit an appear (c) The notice requires be delivered as soon (1) the resident, legal designated represents (2) for residents who recommunity-based waits	relocation; tact information for the resident has been relocated provider; In for the Office of Interm Care and the Office rental Health and relities; cable, the approximate date in which the resident is the facility, or a statement but currently known; and rethe facility refuses to rvices after a relocation, the to appeal under section must provide contact rency to which the resident I. I. d under paragraph (b) must as practicable to: representative, and retive; receive home and ver services under chapter			
	(1) the resident, legal designated representation (2) for residents who recommunity-based wait 256S and section 256 manager; and	representative, and ative; etive; receive home and			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 33 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPP	PLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			MIT AVENUE N			
SUMMIT RIDGE PLACE			PIDS, MN 5637			
(X4) ID SUN	MMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX (EACH D	DEFICIENC'	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
01060 Continued Fr	om page	e 33	01060			
if the resident returned to the (d) Following refusal to propertion a termination process in this This MN Required control of the findings in	t has been active an empty and triggers and the potential of the potential	en relocated and has not within four days.  rgency relocation, a facility's using or services constitutes gers the termination n.currently known; and  t is not met as evidenced  and record review, the vide a written notice with e resident, legal esignated representative; the notification to the Office ong-Term Care (OOLTC)  I not return from the within four days for two of				
8, 2022, after resident a ba facility five da	attempt nana. Th ays later	ing to force feed another ne resident returned to the on September 13, 2022. R1 acility on September 22,				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 34 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>,</b> , ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		30601	B. WING	_	03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
SUMMIT F	RIDGE PLACE	1325 SUI	MMIT AVENUE NO	ORTH	
JOIVIIVII I	IDOL I LACL	SAUK RA	APIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
01060	Continued From page	e 34	01060		
	and any new service periodic contact information of a fixed properties or range of dates with expected to return to a statement that, if the housing or services a resident has the right 144G.54. The facility information for the again may submit an appear of the services	elocation; ct information for the resident has been relocated provider; for the OOLTC; able, the approximate date in which the resident is the facility, or a statement ot currently known; he facility refuses to provide fter a relocation, the to appeal under section must provide contact ency to which the resident II.  In a lacked notification to the ent had been relocated and refacility within four days.  In acked documentation of the ent had been relocated and resident started hitting and mober. R2's progress notes a returned to the facility six ber 13, 2022. The resident acility on September 20, mospital progress notes was sent to the emergency of 2022, and discharged on written notice that			
	discharged from the fa 2022. The resident's hadicated the resident room on September 7 September 13, 2022.	acility on September 20, nospital progress notes was sent to the emergency 7, 2022, and discharged on written notice that			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 35 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30601	B. WING		C 03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SUMMIT RIDGE PLACE		MMIT AVENUE NO			
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	APIDS, MN 56379	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLETE	
01060 Continued From pag	e 35	01060			
location to which the and any new services - contact information - if known and applic or range of dates with expected to return to that a return date is - a statement that, if housing or services resident has the right 144G.54. The facility information for the amay submit an appear In addition, R2's reconstructed to the construction of the amay submit an appear of the construction o	resident has been relocated provider; for the OOLTC; table, the approximate date hin which the resident is the facility, or a statement not currently known; the facility refuses to provide after a relocation, the to appeal under section must provide contact gency to which the resident al.  Ord lacked notification to the dent had been relocated and he facility within four days.  at 11:30 a.m., regional is (RDO)-A confirmed notices for R1 and R2 and the notified.				
01070 144G.52 Subd. 10 R	ight to return	01070			
reason, including an facility shall not refus	emergency relocation, the se to allow a resident to not housing has not been				
This MN Requireme by:	nt is not met as evidenced				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 36 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	30601	B. WING		C 03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
SUMMIT RIDGE PLACE	1325 SUI	MMIT AVENUE NO	ORTH		
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379	)		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
01070 Continued From page	36	01070			
Based on interview ar licensee failed to allow residents (R1, R2) aft emergency room, althissued a notice of terrihousing. Hospital recowould not accept R1 amedically cleared to reavailable and there were indicated the licensee additional services R2 one to one staffing for the ability to manage licensee failed to offer return as a housing-onecessary services pure This practice resulted violation that did not he safety but had the pot resident's health or sacause serious injury, it was issued at a patter limited number of resist than a limited number situation has occurred found to be pervasive.  The licensee's Uniform Living Services and Aupdated March 24, 20 under Dementia Carefacility was prepared to behaviors. On page 1	and record review, the weather they were sent to the rough the licensee had not mination of services or ords indicated the licensee and R2 back after being eturn as a nurse was not ere concerns for staff and and R2 spent five days in the ing for the facility to allow wer, the licensee's UDALSA could provide the land R2 required including a special circumstances and challenging behaviors. The rany option for R1 or R2 to make a special with the rovided by another agency.  In a level two violation (a parm a resident's health or rential to have harmed a afety, but was not likely to mpairment, or death) and an scope (when more than a dents are affected, more of staff are involved, or the direpeatedly; but is not				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 37 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		C	
		30601	B. WING		03/21/2023	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT R	IDGE PLACE	1325 SUI	MMIT AVENUE N	ORTH		
		SAUK RA	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
01070	Continued From page	e 37	01070			
	to indicate what the special be.  R1 R1's diagnoses include encephalopathy (a bracentusion, disorientation)	ecial circumstances would  led Wernicke's ain disorder that can cause ion, and lack of muscle induced dementia, and				
	1, 2020, and began re	I to the facility on December eceiving services under the a change of ownership 2022.				
	The resident's record current service plan.	lacked evidence of a				
	recent assessments. August 11, 2022, indicated with the completed with the completed with the completed with the complete of t	lacked evidence of any A progress note entered on cated a 90 day assessment with no concerns noted. The be jovial and cooperative.				
	resident to resident al	ted the resident had o staff and resident and tercations with aggressive ting staff and trying to feed				
	emergency room for a behaviors" and return Tuesday, September	ne resident was sent to the property in the pr				
	R1's emergency room indicated a medical w	history and physical ork-up was completed and				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 38 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		, Joil J		C
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E, ZIP CODE	
CUMMIT DIDGE DI ACE	1325 SUI	MMIT AVENUE NO	RTH	
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
01070 Continued From page	je 38	01070		
the resident's ammore could be the cause of The resident was stated decrease ammonia the resident at the september 8, 2022. 1:11 a.m., the emerge documented they had to the facility that even but "unfortunately we that this evening. We [September 9, 2022] five days, the resident emergency room was her to return.  Psychiatry notes from indicated "inpatient or return.  Psychiatry notes from indicated "inpatient or recommended as pather behaviors, they not meeting her need aggressive behaviors personality structure behaviors are intent. Hospital records incomprogress note from several progress note fro	nia levels were high and that of the increased behaviors. The increased behaviors arted on a medication to evels. Psychiatry evaluated equest of the facility. Inded the resident be the facility the evening of On September 9, 2022, at gency room physician and tried to discharge R1 back ening [September 8, 2022], are are unable to accomplish e will try discharge tomororw. In Over the course of the next intremained in the aiting for the facility to allow the september 8, 2022, geri-psych is not attent is completely aware of are intentional when staff are indentional when staff are des. I do question if patients is more related to her than from dementia as onal."	01070		
noted, "Called patient 1900 (7:00 p.m.) on nurse (RN)-C]. Write it was passed on in going to take this particular [RN-C] states that "I	nt's care facility shortly after 9/8. Spoke with [registered er discussed with [RN-C] that report that they were not tient back to their facility.  didn't specifically say that."			
have elevated amme contributing to the in then stated that "unf	d that patient was found to onia, and that could be creased behaviors.[RN-C] ortunately this isn't her first er explained that we would			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 39 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SUM	MIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RAI	PIDS, MN 5637	9	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
01070 Continued From page	e 39	01070		
be administering Lace elevated ammonia. [Finot be taking this patinasked why, [RN-C] sate behaviors she has hare residents." [RN-C] further provider at the facility needs a geri-psych ethey had the ability to their facility. [RN-C] at been seen by behavior not specifically geri-perior patient and determine treatment is unnecess return to facility and for Writer called and talk told that managemen Writer called by [region (RDO)-A]. [RDO-A] so "SPECIFICALLY said returning patients need clinical services (DCS "SPECIFICALLY said patient back tonight." phone number and it nurse notified and should be update that [daughter there while alternative worked on Writer rehas the right to return accomodations and the updated."	culose to correct the RN-C] stated that they would ent back tonight. When aid "because of the ad towards staff and other ther expressed that the had stated that the patient valuation. Writer asked if perform this assessment at dvised that the patient had bral health at the facility, but sych. Psych here evaluated ed that acute care inpatient sary. Patient appropriate to collow up with [physician]. ed to staff at facility and was at staff would return call. conal director of operations tated that the facility that anyone calling about ed to talk to [director of S)-D]" and that they they won't be taking this Writer asked for [DCS-D] was provided. Charge e contacted [DCS-D]."  Ided a social worker's otember 9, 2022, noted, ummit Ridge and provided of would like pt [R1] to return			
progress note from S	eptember 12, 2022, which it Ridge ALF (assisted living			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 40 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		_		С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CUMMIT DIDOE DI ACE	1325 SUM	IMIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RA	PIDS, MN <b>5</b> 637	9	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
01070 Continued From page	÷ 40	01070		
facility) to coordinate SW (social worker) were not in yet and to called again and spokinformed SW that the in today and that she HR (human resources stated she would come Received phone call the Ridge Corporate static return to their facility of Reviewed conversation agreement that patien (September 12, 2022 SW would follow up were message for [ombude situation. Received castating she has been Summit Ridge confirm today. [Ombudsman] situation and stated [Fresolve this. Left messituation and stated [Fresolve this. Left messituation and requested (9/13). SW agreed to patient's daughter that hospital tonight with proposed (9/13). SW agreed to patient's daughter that hospital tonight with proposed (9/13) and requested (9/13). SW agreed to patient's daughter that hospital tonight with proposed (9/13) and requested (9/13). SW agreed to patient's daughter that hospital tonight with proposed (9/13) are commending inpatient treatment or geri-psyconal systems of the patient o	patient's return to facility. as advised nursing staff call back after 0900. SW the with [RDO-A]. [RDO-A] r nurse was unable to come was working with corporate to the solution of the solutio			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 41 of 82

STATEMENT OF DEFICIENT AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		С	
		30601	B. WING		03/21/2023	
NAME OF PROVIDER OR	SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT RIDGE PLAC	CE	1325 SUI	MMIT AVENUE N	ORTH		
		SAUK RA	APIDS, MN 5637			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE	
01070 Continue	d From page	e 41	01070			
processe	s) and depre	ession.				
28, 2022, current lic occurred	and began censee after on June 1, 2	to the facility around April receiving services under the a change of ownership 2022.				
	ent's record sessments.	lacked evidence of any				
episodes aggressiv hard eno	of "resident re behavior" ugh to draw ticking, and t	to staff altercations with including pinching staff blood, hitting, punching, throwing things at staff and				
detailing resident t was repo	nine separat o staff altero rted to have	d several incident reports te resident to resident and tations where the resident hit, bit, pushed, punched, sidents and staff.				
indicated called aft shower. The residual called formula called aft shower.	on September R2 became the resident cy room to be lent returned er 13, 2022, or discharge	m September 8, 2022, ber 7, 2022, the police were ne combative during a was taken to the e evaluated for behaviors. If from the hospital on five days after she was back to the facility.				
assessme an inpatie was evalu	ent from Sep ent psych co uated. A geri	tember 7, 2022, indicated nsult was placed and R2 atric psych provider was edication changes were				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 42 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
					С	
	30601	B. WING		03	/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE			
TO THE OF THE VIBER OR GOTT EIER		MMIT AVENUE NO				
SUMMIT RIDGE PLACE		APIDS, MN 56379				
(X4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
01070 Continued From page	42	01070				
recommended. On Sepa.m., the emergency redocumented, "at this till recommending discharbeen unable to get and care facility to determine hom and except (sic) the course of the next five remained in the emerges facility to allow her to reduce the from Friday, September "Received update after spoke with AL (assisted informed writer she received update after spoke with AL (assisted informed writer she received update after spoke with AL (assisted informed writer she received indicating they are willing not until Monday 9/12 at Writer called [hospital she did see notes from follows that indicated the noon and that it is too I Hospital progress notes from Monday, September "Received return call from Monday, September "Received return call from were unable to secure requested patient return (social worker) agreed requested names of altoptions to discuss with provided information for Called Summit Ridges facility) to coordinate postument of the call back after 0900. spoke with [RDO-A]. [For the comment of the call back after 0900. spoke with [RDO-A].	otember 8, 2022 at 1:14 com physician me, inpatient psych is rge. However, we have old of the patient's memory ne if they will accept return his medical plan." Over the days, the resident ency room waiting for the eturn.  s included a progress note er 9, 2022, which noted, r Psychiatric Provider who d living) Provider. RN revived a call from AL ng to take patient back but as it is too late in the day. employee] who indicated a AL on other clients she hey must return onsite by ate now for today." s included a progress note over 12, 2022, which noted, rom [DSC-D] stating they nursing staff today and rn tomorrow (9/13). SW to this. [DCS-D] also ternative placement patient's family. SW or [other communities.] e ALF (assisted living atient's return to facility. ng staff were not in yet and SW called again and RDO-A] informed SW that to come in today and that					

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 43 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			
	30601	B. WING		C 03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE		
	1325 SUI	MMIT AVENUE NO	ORTH		
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379	9		
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PRÉFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
01070 Continued From page	e 43	01070			
,	)-C stated she had only				
	for less than six weeks.				
	R1 and R2 had a history of aggressive towards other				
	times. RN-C stated she				
	ch with the decision to				
readmit R1 and R2 a	nd it was handled by				
corporate. RN-C state	ed she did not complete the				
	dition assessments for either				
residents and that an					
' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	-C stated she was so new at				
	she didn't know the rules				
are regulations they h	nau to aunere to.				
On March 16, 2023, a	at 1:45 p.m., director of				
	S)-D stated there were two				
residents who were d	combative and putting other				
residents and staff in	danger so they had to call				
· · · · · · · · · · · · · · · · · · ·	e residents tried to swing at				
	ce took her to the ER for a				
• -	onfirmed the facility is a				
	inity that serves residents ehaviors. DCS-D stated the				
	ours saying they didn't see				
	the residents so were				
	nd she had said they weren't				
	e could do an assessment to				
ensure they were app	propriate since the residents				
	her residents. DCS-D stated				
	r the hospital said they				
•	the residents in the ER over				
	stated she wanted the				
	sych eval before returning sure the facility nurse				
assessed them. DCS	•				
	e a full universal assessment				
	idual abuse prevention plan				
	idents were not abusing				
others or at risk of be	ing abused and that would				
		1			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDPLANC	DE CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
			R WING		C
		30601	D. VVIIVO		03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SUMMIT F	RIDGE PLACE		MIT AVENUE N		
			PIDS, MN 5637		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETE
01070	Continued From page	e 44	01070		
O I U / U	need to be done before they watned to make assessment was also facility assessments of DCS-D confirmed she assessments for R1 at they were done removed. On March 21, 2023, a director of operations she undersood, the het the residents back aft of the night and it can the other residents were turned. RDO-A state the hospital they could was not available. Ho on call nurse had compose assessments remotel always close to the factor of the readmission. The licensee's 1.05 R Health Care Facility, indicated "the facility of that are readmitted to extended period at an be re-assessed prior the facility is still capate the resident. Based of facility may not be about may have to adjust the resident.	re returning. DCS-D stated sure a medication completed and that all would be done in person. It had not reviewed the two and R2 and was not aware tely and not completed.  At 11:15 a.m., regional (RDO)-A stated from what ospital had wanted to send for hours toward the middle fine down to they didn't feel build be safe if they led she did not recall telling didn't return because a nurse limit wever, RDO-A stated the impleted the readmission by as the on call nurse is not incility. RDO-A stated the insite staff had managed on process.  The eadmission from other dated July 22, 2022, will ensure that residents in the facility after an inother health care facility will to re-admission to ensure able of meeting the needs of in the assessment the life to take the resident back in the care plan to meet the dent after a change in			
	TIME PERIOD FOR 0 days.	CORRECTION: Seven (7)			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 45 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT F	RIDGE PLACE	1325 SU	MMIT AVENUE N	ORTH		
		SAUK R	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	) BE COMPLETE	
01540 SS=F	· · · · · · · · · · · · · · · · · · ·	IG IN DEMENTIA CARE	01540			
	care, direct-care employees on topics specified unworking hours of the exthis initial training is constructed and provide direct care employee on site who eight hours of training dementia care and whand assist if issues are requirements under provide available new employee until the complete. Direct-care least two hours of training dementia for each 12 thereafter;	ght hours of initial training der paragraph (b) within 80 employment start date. Until omplete, an employee must e unless there is another has completed the initial on topics related to no can act as a resource rise. A trainer of the				
	Based on interview and licensee failed to ensure (registered nurse (RN (ULP)-F, ULP-K, ULP assisted living directors)	nd record review, the ure five of five employees  1)-C, unlicensed personnel  2-L, and former licensed  1 (LALD)-M) received the ementia care training in the				
	violation that did not he safety but had the potential resident's health or saccause serious injury, it was issued at a wides problems are pervasive.	in a level two violation (a narm a resident's health or tential to have harmed a afety, but was not likely to impairment, or death), and spread scope (when we or represent a systemic ed or has potential to affect				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 46 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT F	RIDGE PLACE		MMIT AVENUE N APIDS, MN 5637			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
01540	Continued From page	46	01540			
	a large portion or all o	f the residents).				
	The findings include:					
	The licensee was grandementia care license ownership occurred o	•				
	services to the license RN-C's employee rece	d provide direct care and				
	care and services to the ULP-F's employee red required amount of determined time frame.	29, 2022, to provide direct he licensee's residents. cord lacked evidence the ementia care training in the				
	care and services to the ULP-K's employee red	5, 2022, to provide direct he licensee's residents. cord lacked evidence the ementia care training in the				
	care and services to the ULP-L's employee rec	10, 2022, to provide direct he licensee's residents. cord lacked evidence the ementia care training in the				
	LALD-M LALD-M was hired Ap oversight of the licens	ril 29, 2022, to provide ee's operations.				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 47 of 82

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		30601	B. WING		03/21/2023	
NAME OF PRO	OVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT RI	DGE PLACE	1325 SUI	MMIT AVENUE N	ORTH		
OOMMIT IX	DOL I LAGE	SAUK RA	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
01540	Continued From page	47	01540			
	' '	ecord lacked evidence the mentia care training in the to the terms of				
	director of operations thought dementia train employees within the not have any docume completed. RDO-A state verbally gone over an	(RDO)-A stated she ning was completed on all required time frame but did ntation to show it had been ated dementia training is d discussed upon hire and				
	that it's something they talk about with employees. RDO-A stated the dementia training consisted of printing a packet of paperwork from Relias (online education system) and employees would take it home and review it on their own.					
	RDO-A stated she thought it was about eight hours of training but was not sure how long it took staff to read through the printed out slides. RDO-A stated they did not have any documentation from employees hired prior to the June 1, 2022, change of ownership to show they					
	could not confirm if the the the required training.	ed dementia training and e prior owner had provided				
	regardless of working Assisted Living Progra	icated all Cornerstone staff in a facility licensed as an am with Dementia will ementia-specific education				
	Training, dated Augus care employees at ass care licensed facilities hours of initial training	rovided titled 5.03 Dementia It 1, 2021, indicated direct sisted living with dementia would complete eight within 80 hours of the E. Supervisors of direct care				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 48 of 82

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BUILDING.				
		30601	B. WING		03/2	; :1/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE			
OLINANAIT F		1325 SU	MMIT AVENUE NO	RTH			
SUMMITE	RIDGE PLACE	SAUK RA	APIDS, MN 56379				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
01540	Continued From page	e 48	01540				
	staff were to complete training within 120 ho date.	e eight hours of initial urs of the employment start					
	No further information	was provided.					
	TIME PERIOD FOR (21) days	CORRECTION: Twenty-One					
02110 SS=C		cies	02110				
	required in the licensial assisted living facility licensee must develop and procedures that a (1) philosophy of how based upon the assistivativates, mission, and person-centered care shall be implemented (2) evaluation of behadesign of supports for including nonpharmatic person-centered and (3) wandering and egrovides detailed instrained aresident elopes; (4) medication manages assessment of reside of medications; (5) staff training specific (6) description of life endow activities are imposed.	with dementia care p and implement policies address the: services are provided ted living facility licensee's promotion of and how the philosophy ; avioral symptoms and r intervention plans, cological practices that are evidence-informed; ress prevention that ructions to staff in the event  gement, including an ants for the use and effects ding psychotropic  fic to dementia care; enrichment programs and alemented; ily support programs and mily engaged; public address and emergencies and					

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 49 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				С	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		MIT AVENUE N			
SUMMIT RIDGE PLACE		PIDS, MN 5637			
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
02110 Continued From pag	e 49	02110			
and from outside me (10) safekeeping of r (b) The policies and	and the residents' legal and				
This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives.					
This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/resident and does not affect health or safety) and is 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:					
The facility currently Dementia Care licens	held an Assisted Living with se.				
living with dementia of procedures. The police of provided did not included the provided of behavior of behavior of procedures.	r the licensee's assisted care policies and cies and procedures				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 50 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT F	RIDGE PLACE		MMIT AVENUE N APIDS, MN 5637			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
02110	Continued From page		02110			
	detailed instructions to resident elopes; - medication manager assessment of resider of medications, included medications; - limiting the use of pure systems for emergency only; - transportation coording and from outside medications only; - transportation coording and from outside medications of the safekeeping of resident of the safekeeping of resident of the sure if they had the required dementia politic check.  On March 23, 2023, and again requested the and care policies. Regional emailed the investigate to dementia training by the above mentioned.  On March 24, 2023, and she was not sure if they and would have to check.	evidence-informed; as prevention that provides o staff in the event a ment, including an ints for the use and effects ing psychotropic ablic address and intercomples and evacuation drills anation and assistance to dical appointments; and ents' possessions.  It 11:20 a.m., regional (RDO)-A stated she was elabove mentioned icies and she would have allowed to experience of the event policies related and nurse manager (RNM)-Elaor several policies related at nurse manager (RNM)-Elaor several policies related at no policies that covered topics.  It 9:15 a.m., RDO-A stated ey had the required policies eck with the corporate office ing they had as she was a policies.  It was provided.				
	No further information	was provided.  CORRECTION:				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 51 of 82

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		30601	B. WING		C 03/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
CLINANALT F	NDOE DI AGE	1325 SU	MMIT AVENUE NO	ORTH	
SUMMITE	RIDGE PLACE	SAUK RA	APIDS, MN 56379	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
02320	Continued From page	51	02320		
02320 SS=H		Appropriate care and	02320		
	care and other assisted continuity from people and competent to per sufficient numbers to services agreed to in and the service plan.  This MN Requirement by: Based on interview are licensee failed to ensure provided in accordance service plan and by pertrained and competent 2 of 2 residents (R1, Final The licensee failed to safety concerns include abusive behaviors of residents and staff, far implement intervention incidents, and failed to how to manage behave.  This practice resulted violation that harmed safety, not including so or death, or a violation lead to serious injury, was issued at a patter limited number of residents and limited number.	e who are properly trained form their duties and in adequately provide the the assisted living contract is not met as evidenced and record review, the are care and services were be with an up-to-date eople who were properly at to perform their duties for R2) with records reviewed. And act on their knowledge of ding verbal and physically R1 and R2 towards other alled to assess and ans to mitigate further to train and educate staff on wiors.  In a level three violation (a a resident's health or serious injury, impairment, and that has the potential to impairment, or death), and an scope (when more than a dents are affected, more of staff are involved, or the direpeatedly; but is not			
	The findings include:				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 52 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING		
	30601	B. WING		C 03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SU	MMIT AVENUE N	ORTH	
SOMMIT RIDGE PLACE	SAUK R	APIDS, MN 5637	9	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
02320 Continued From page	e 52	02320		
Living Services and A updated March 24, 29 under Dementia Care indicated that the factor manage challenging Section 9: Staffing into provide one-to-one circumstances. No conficate what the specific be. In addition, page there was a registere time.  On March 21, 2023, a assisted living director confirmed the facility Fridays and on call of the RN works at a sist miles away) on the director care away on the director away on the director away on the director away.	behaviors. On page 15, dicated the facility was able e staffing for special omments were listed to ecial circumstances would 16 of the UDALSA indicated of nurse (RN) on-site full at 9:30 a.m., the licensed or in residence (LALDIR)-B RN was on site Monday and therwise. LALDIR-B stated ster facility (approximately 65 ays she is not at the facility. RN is always on call and a company but is not onsite			
confusion, disorienta	ded Wernicke's rain disorder that can cause tion, and lack of muscle I induced dementia, and			
1, 2020 and began re	d to the facility on December eceiving services under the a change of ownership 2022.			
The resident's record current service plan.	lacked evidence of a			
The resident's record	lacked evidence of any			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 53 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						С
		30601	B. WING		03/	21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
CLIMANALT F	NDCE DI ACE	1325 SUN	MMIT AVENUE NO	RTH		
SUMMITE	RIDGE PLACE	SAUK RA	APIDS, MN 56379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
02320	Continued From page	53	02320			
	August 11, 2022, indicated to resident was noted to the resident's record current Individual Abuse Progress notes from A resident's September	A progress note entered on cated a 90-day assessment with no concerns noted. The be jovial and cooperative.  lacked evidence of a se Prevention Plan (IAPP).  August 1, 2022, through the 22, 2022, discharge were				
requested.  Progress notes provided began on September 7, 2022, and included the following notes: -September 7, 2022, at 8:01 a.m., a behavior note entered by registered nurse (RN)-C noted "Resident to staff altercation with aggressive behavior. Per RA [resident assistant] staff, resident asked for ice, RAs saw cup she had was very dirty with brown water, so staff offered to get her a clean cup to fill and resident attempted to bite staff. Resident got in RA's face, began name calling, hitting, and pushing. Per RA staff, resident was using very vulgar language such as "shove a banana up your cunt." "Go fuck yourself." "I hope you get raped and like it." Staff choose (sic) to walk away in another direction until resident stopped following them. Blue stone physicians updated."						
	note entered by on carattempting to force feet banana at the table. So other residents. [R1] It started to take items of things over, she threw staff hitting her in the bent over to pick up the	Staff asked her to not feed				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 54 of 82

STATEMENT O AND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		30601	B. WING		03/21/2023	
NAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMIT RID	GE PLACE	1325 SUI	MMIT AVENUE N	ORTH		
	- CLILAGE	SAUK RA	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	) BE COMPLETE	
02320	Continued From page	54	02320			
	and struck her in the knowled away from the angrily went to her applicant locked it. The state he PCP [primary care orders received to call services]. Resident was relayed to Passing the propriate placement of this was relayed to Passing the propriate placement were implemented and submitted.  September 13, 2022, noted entered by RN-discharged from the [haggressive behaviors hat resident should read supervised when other residents as guarent were implemented and supervised when other residents as guarent well-being of staff and community." No new implemented and a Massing the properties of staff and community and a massing the properties of staff and community. The new implemented and a Massing the properties of the properties of staff and community and a massing the properties of the properti	pack of the head. Staff resident and the resident artment, slammed the door if reported the incident to e physician] and verbal i EMS [emergency medical as transported to ER psychiatric evaluation of es (sic) current wishes are in't return to the community other vulnerable adults. CP who is working with ER worker] to find more t. No new interventions d a MAARC report was not  at 3:00 a.m., a behavior C noted, "Resident hospital] with diagnosis ofGuardian is requesting emain in her room for meals out in the community with ardian is concerned for the l residents within the	02320			
1 1 ii	change of condition as 13, 2022, the day she The assessment was ndicated R1 had a mo	a partially completed ssessment from September returned from the hospital. completed remotely and ood disorder and will hit, e call. The resident was				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 55 of 82

STATEMENT OF DEFICIENCIES			(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E. ZIP CODE	
		MMIT AVENUE NO		
SUMMIT RIDGE PLACE		APIDS, MN 56379		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
02320 Continued From pa	ge 55	02320		
noted to have beha	viors with a history of harming			
	h physically abusive to staff,			
	anxious/paranoid or			
•	r. The resident was noted to			
•	sive, oriented to person, uation and had no apparent			
memory loss and c	• •			
	ent events and was able to			
make safe judgmer	nts and function appropriately			
	The assessment further			
	ent had behavioral symptoms			
redirection was effe	d physical aggression and			
redirection was ene	ouve.			
The resident's reco	rd contained a care plan			
•	ber 13, 2022. The section			
	for the resident's behaviors			
,	interventions listed. The care esident did not have memory			
•	Il and retain information.			
	, at 8:50 a.m., unlicensed stated she worked frequently			
	ident had behaviors just			
	s very physically abusive			
	ents and staff. ULP-G stated			
the only interventio	ns she was aware of was			
	dent or calling her family to			
	her. ULP-G stated she had			
	ed R1 push other residents on ones. ULP-G stated staff would			
	emselves between R1 and			
•	ause she would try to push,			
	ngs at them. ULP-G confirmed			
	e afraid of R1 and her			
	n going on for several months.			
	nad reported the resident to			
file a MAARC report	s to management but did not			
ille a MAARC Tepol	t Hersell.			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				C	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		MMIT AVENUE N			
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 5637	9		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
02320 Continued From page	je 56	02320			
On March 21, 2023, she would leave wo bruises from R1 and residents too. ULP-calm the resident do away from her if the but that wasn't alwa had targeted one re of her behaviors tow ULP-J stated R1 has ince at least Nover was aware of a time called police after the ULP-J stated the powith her aggression police she'd bit the swas taken to the ER aware the resident hissues. ULP-J stated on dementia but did managing difficult of On March 21, 2023, stated she had work 2022 to October 202 would manipulate of high functioning, so LALDIR-B stated R1 towards staff and rehit and yell. LALDIR R1 or get her to calmate triggered her. LALD the ER after trying to when they told her so off. R1 threw a removant said she was go called the police. LA	at 9:20 a.m., ULP-J stated is on a nightly basis with that R1 would hit other stated they would try to wn and keep other residents weren't able to redirect her we effective. ULP-J stated R1 sident and would focus a lot ards the other resident. It been having behaviors aber 2021. ULP-J stated she when another staff member eresident bit her breast. Ice were called to help deal and the resident had told taff member again, so she uLP-J stated she was ad dementia and cognition is she had done video training not get any training on challenging behaviors.  at 10:40 a.m., LALDIR-B ed as ULP from February 12. LALDIR-B stated R1 her residents and was more she knew who to target. Would be aggressive sidents and would pinch and 13-B stated they'd try to redirect in down and figure out what R-B stated R1 was sent to be feed another resident and he couldn't do that, it set her te at a staff members head bing to kill herself, so they LDIR-B stated she knew they on in the ER but it didn't do it sure what other				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 57 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30601	B. WING		C <b>03/21/2023</b>	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1325 SUMMIT AVENUE NORTH  SAUK RAPIDS, MN 56379						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
02320	Continued From page	e 57	02320			
	behavior disturbance by brain damage from brain that causes difficulty planning, judgment, more processes) and depresses and depresses and began recurrent licensee after occurred on June 1, 2. The resident's record current service plan.  The resident's record current lindividual Abustinesses and the resident's september requested.  Progress notes from A resident's September requested.  Progress notes provided 2022 and included the september 4, 2022, and included the september 4, 2022, and included the september 4, 2022, and entered by RN-C "resident to staff altered Resident pinched staff draw blood. Resident and threw hard toys a Resident flashing her death on staff as well kill us. Incident witness residents. Intervention	leto the facility around April eceiving services under the a change of ownership 2022.  lacked evidence of a lacke				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 58 of 82

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		30601	B. WING		C <b>03/21/2023</b>
NAME OF PROVIDER (	OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PL	ACE		MMIT AVENUE N APIDS, MN 5637		
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
02320 Contin	ued From page	÷ 58	02320		
this tim	ie"				
note er coming offered assista room, i	ntered by RN-Contents out of another that she was was were not the there were not the there were not the there were not the the there were not the there were not the there were not the the the there were not the the the the the the the the the th	at 8:19 a.m., a behavior noted, "resident was resident's room, staff very mad. RA [resident o redirect resident to her oset and punched RA in the tother witnesses at the time			
	g resident to re	d several incident reports esident and resident to staff			
resider hit ano red ma	nt altercation w ther resident to rks. No new in	D p.m., a resident to as reported by ULP after R2 vice in the face, leaving little terventions were noted and eported to MAARC.			
alterca observ chest. away a the bac	tion was reported rubbing and The other resident told R2 to seek. No new inte	p.m., a resident to resident ed by ULP after R2 was other resident's hand on her lent was noted to be pulling stop. R2 hit the resident in erventions were noted and eported to MAARC.			
resider reporte on ano touchir away a interve punchi and the	et and resident ed by ULP after the male resident in the main and told her to go ned, R2 became incident was encident was	D p.m., a resident to to staff altercation were R2 was observed rubbing lent and inappropriately le resident was pushing R2 go away. When staff he very angry and began w interventions were noted not reported to MAARC.			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 59 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30601	B. WING		C <b>03/21/2023</b>	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	O BE COMPLETE	
02320	"being rude, yelling, oresident's rooms, ripp choked, and pushed [hallway."  -August 12, 2022, at 2 reported to have had a resident altercation was observed to be continued and interventions were not not reported to MAAR.  -August 16, 2022, at 8 resident altercation was additional intervention interventions were not not reported to MAAR.  -August 16, 2022, at 8 resident altercation was went in another resident to other resident was not on her forearm after the interventions were not not reported to MAAR.  -August 17, 2022, from ULP completed an incontinued and the resident was not reported to MAAR.  -August 17, 2022, from ULP completed an incontinued and the resident was not resident was not resident was not resident altercation was resident altercation was resident altercation was resident altercation was not reside	eported by ULP after R2 g up and down the hallways alling names, in other ed [staff member's] nail off, staff member] down the  2:17 p.m., the resident was a fall.  3:00 p.m., a resident to as reported by ULP after R2 rawling in to bed with 'roll on top of her." When irect R2, she punched staff e face. A note was entered 16, 2022, indicating "no as needed." No new ted and the incident was a.C.  2:15 p.m., a resident to as reported by ULP after R2 ent's room and pushed her, o fall back on the floor. The ted to have a small scratch he altercation. No new ted and the incident was a.C.  m 3:00 p.m. to 6:00 p.m., sident report after R2 would esidents rooms, even after R2 was noted to keep herventions were noted and eported to MAARC.  5:30 p.m., a resident to as reported by ULP after R2	02320			
	the incident was not reAugust 17, 2022, at 5 resident altercation was	eported to MAARC. 5:30 p.m., a resident to				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 60 of 82

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30601	B. WING		C <b>03/21/2023</b>	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
work thre doc R2 inter not -Au resi repe resi atte swe and note MA -Se was and atte che An Sep 202 sho she dow tool was scre batt to ri	ew coffee at R2 and sumented "We got keeped (sic) going reventions were not reported to MAAR gust 27, 2022, at 7 dent and resident orted by ULP after dent's room and be empting to redirect earing and grabbed would not let go. I would not let go. I would not let go. I would not he incident ARC.  ptember 4, 2022, at 7 dent's room the arm a ptember 5, 2022, at 7 dent's reported by ULP other resident's room the arm a ptember 5, 2022, at 7 dent's reported by ULP other resident's room the arm and ptember 8, 2022, in 22, she "took [R2] in werwhen I went a only allowed me to the only allowed me	ne. The other resident d R2 hit the resident. Staff [resident] to walk away and at her." No new ted and the incident was C.  2:45 p.m., a resident to to staff altercation was R2 entered another roke her TV. Staff reported R2 but she kept yelling and d the staff member's wrist No new interventions were t was not reported to  a resident to staff altercation after R2 pinched a staff	02320			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 61 of 82

` <i>'</i>	DER/SUPPLIER/CLIA FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С	
3060	)1	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMIT RIDGE PLACE	1325 SUM	MIT AVENUE N	ORTH		
	SAUK RAF	PIDS, MN 5637	9		
(X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PREGULATORY OR LSC IDENTIFY)	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETE	
02320 Continued From page 61		02320			
hitting and scratching me. Sister called and both said they couldr didn't know what we want her to Cops were called. [R2] spit on o both. [R2] walked out of the bath shirt and wet socks on, so we had other residents in the living room interventions, ULP-G noted she calmly, moving quickly, moving get herself dress (sic), singing of with a towel so we could leave the put everything she could break, away out of her reach. I gave he called sisters (both). Then policed new interventions were noted and was not reported to MAARC. The sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident returned from the health sent to the emergency room.  The resident was not noted to health sent to the emergency room.  The resident was not noted to health sent to the emergency room.  The resident was not noted to health sent to the emergency room.  The resident was not noted to health sent to the emergency room.	and to shut all and to shut and the incident are resident was a shoot of the shut all and to should be and				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 62 of 82

STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		30601	B. WING		C 03/21/2023	
NAME OF PROVIDER C	OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
	4.05	1325 SUN	MMIT AVENUE N	IORTH		
SUMMIT RIDGE PL	ACE	SAUK RA	APIDS, MN 5637	'9		
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	) BE COMPLETE	
02320 Continu	ıed From nage	62	02320	DEFICIENCY		
			02020			
everyor MAARO place. It hands to hands to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified no other she did she could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with or kiss notified and the could be used to happen bed with the could be us	ne was ok with C and no other JLP-G stated I up another may ne and redirections in a different mand that the but the resident interventions in not feel safe was and she was were made restated RDO-A ts and she was were made restated the only of come in and to come in and to come in and to come in and the come in an and the come in an analysis and th	ily was notified and it' so it was not reported to interventions were put in R2 would try sticking her le resident's shorts and and staff would try to t when they saw it leated R2 would try to climb in leale resident, hold his hand, he resident's family was lent was his own person so s were done. ULP-G stated working with R2 and felt like lear residents safe either. It was notified of all those is not sure if any MAARC legarding R2's behaviors. It with her, if the resident's sit with her, if the resident's lolent, they would call the				
both Rawith bounterver room to come in had to room at ULP-F "there worked didn't gothe nur challen any trainshe did	th residents and relax, redirect and sit with his being diag stated police of the any other great and great any other	at 9:20 a.m., ULP-F stated d have physical altercations and staff. ULP-F stated cluded sending her to her ting, and calling family to her. ULP-F stated the police R2 wouldn't stay in her nosed with COVID-19. Idn't come as they stated, ey could do because I care unit." ULP-F stated she uidance or direction from handle either resident's and could not recall getting RC reporting. ULP-F stated e could care for R2 towards as too dangerous and she				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 63 of 82

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E, ZIP CODE	
	1325 SUN	MMIT AVENUE NO	ORTH	
SUMMIT RIDGE PLACE		APIDS, MN 56379		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
02320 Continued From pa	ge 63	02320		
still had scars on h and hit by R2.	er arms from being scratched			
R2's behaviors dep she'd be great other ULP-J stated R2 would go after other stated R2 had some inappropriate behaviored and that they had another resident or to touch several of would tell her no another reported to My guardian was ok with the police had to be and spit on staff and responding officers and R2 returned from any new intervention manage either resistent of the shew R2 had anything else on word on March 21, 2023 stated R2 would go laughing then smarstated if R2 had be a redirect or try activities.	ended on the day, sometimes r times everything was wrong. Could hit and pinch staff and r residents at times. ULP-J e other episodes of vior towards other residents aught her giving oral sex to acc. ULP-J stated R2 would try her male residents and they are to stop but she wouldn't and chairs so not able to get away. It is it was fine. ULP-J stated R2's the it, it was fine. ULP-J stated e called on R2 after she hit d she did the same to the could be dead of the same to the could be consornew direction on how to dent's behaviors. ULP-J stated dementia but didn't known hat she had.  The promote the face of the could be			
submitted for any of altercations. LALD of any new interver	MAARC reports had been f the resident to resident R-B stated she was not aware itions or changes to either are after they returned from			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 64 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				C	
	30601	B. WING		03/21/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		IMIT AVENUE N			
SUMMIT RIDGE PLACE		PIDS, MN 5637			
(X4) ID SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
02320 Continued From pag	e 64	02320			
On March 21, 2023,	at 11:15 a.m., the Regional				
Director of Operation	s (RDO)-A was questioned				
about the licensee's	UDULSA. RDO-A stated she				
_	e UDALSA indicated the				
	to-one staffing for special				
	-A stated, "That's a head				
• •	d we are not able to do and confirmed that was not				
	LSA. RDO-A stated the				
	s the facility was able to				
	aluated as incidents arise				
	e able to manage behaviors				
where there was phy	sical harm to others. RDO-A				
stated they would be	able to manage behaviors				
that included altercat	ions with staff "to a degree,"				
	d verbal behaviors and the				
	ood job of training staff to				
	ors. RDO-A confirmed there				
	on site. RDO then stated				
	R1 or R2 had service plans, vention plans, behavioral				
assessments, or other	•				
demonstrate behavio					
	ressed. RDO-A stated with				
	ship on June 1, 2022, they				
	e records from the prior				
owner and was not s	ure what had been				
completed by facility	staff. RDO-A stated she did				
	ent record was missing those				
_	were requested by the				
	confirmed the September				
	nt was not an accurate				
	R2's current condition as ondition assessments were				
	by an on call nurse who was				
	ty. RDO-A stated that using				
	vention for behaviors was				
·	tuation was different and it				
•	ff member's comfort level				
with the behavior and	d if there was a safety issue.				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 65 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	1325 SUN	MIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RA	PIDS, MN 5637	9	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
02320 Continued From pag	e 65	02320		
RDO-A confirmed an	intervention used for R1			
	the hospital was keeping her			
in her room as that's				
	onfirmed the facility had not			
	a restraint or if other			
interventions would I	nave been more effective			
and they had only im	plemented it because family			
requested they do so	o. RDO-A stated she was			
	oorts for both R1 and R2 and			
	of resident to resident			
	residents. RDO-A stated she			
_	had been reported to			
	ity had done in house			
	es of the investigations were			
·	RDO-A stated they did not stigations and did not have			
	what their investigations			
	firmed many of the incident			
	rtially filled out. RDO-A			
	the incidents would be			
reportable but that d	rection would come from			
nursing, not the region	onal director as the regional			
director is not respor	nsible for nursing. RDO-A			
confirmed she was a	mandated reporter. RDO-A			
	ncerns about readmitting R1			
	concerns for the other			
	ere not sure they could keep			
	afe from R1 and R2. RDO-A			
	report on behalf of the other			
	afety concerns were not			
facility.	and R2 readmitted to the			
raciity.				
The licensee's 6.05	ndividual Abuse Prevention			
	ugust 1, 2021, indicated the			
facility would develo				
	vention plan for each			
•	residents in an assisted			
living are categorical	ly considered vulnerable			
adults.				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 66 of 82

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		30601	B. WING		03/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMIT F	RIDGE PLACE	1325 SUN	MIT AVENUE N	ORTH		
	- LAGE	SAUK RA	PIDS, MN 5637	<b>'9</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETE	
02320	Continued From page	e 66	02320			
	dated February 1, 202 Management Service record containing all of health and residency	esident Record policy, 22, indicated Cornerstone is will retain a resident of the required and pertinent information needed for each resident admitted into				
	Health Care Facility, of indicated "the facility of that are readmitted to extended period at an be re-assessed prior the facility is still capathe resident. Based of facility may not be able or may have to adjust	will ensure that residents the facility after an other health care facility will to re-admission to ensure able of meeting the needs of				
	No further information	was provided.				
	TIME PERIOD FOR O	CORRECTION: Seven (7)				
02360	144G.91 Subd. 8 Free	edom from maltreatment	02360			
	sexual, and emotional exploitation; and all for covered under the Vu	Inerable Adults Act.				
	This MN Requirement by:	t is not met as evidenced				
	The facility failed to e	nsure two of two resident ere free from maltreatment.		No Plan of Correction (PoC) required.  Please refer to the public maltreatment report (report sent separately) for details.	nt	
	Findings include:			of this tag.		

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 67 of 82

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, 5012511(0		C	
		30601	B. WING		03/21/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CHMMIT D	IDGE PLACE	1325 SU	MMIT AVENUE N	ORTH		
SUMMIT K	IDGE PLACE	SAUK RA	APIDS, MN 5637	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
02360	Continued From page	67	02360			
	issued a determination and the facility was remaitreatment of R1 are incidents which occurrences	nd R2, in connection with red at the facility. Please treatment report for details.				
03000 SS=F	626.557 Subd. 3 Timi	ng of report	03000			
	been maltreated, or would vulnerable adult has so which is not reasonable immediately report the common entry point. It vulnerable adult solely admitted to a facility, a required to report sust individual that occurred unless:  (1) the individual was another facility and the believe the vulnerable the previous facility; of (2) the reporter knows that the individual is an in section 626.5572, so (a), clause (4).  (b) A person not requiperovisions of this sections as described above.  (c) Nothing in this sections with the individual is an individual is an insection of this sections of this sections of this sections of this sections as described above.	cole adult is being or has the has knowledge that a sustained a physical injury by explained shall a information to the fan individual is a because the individual is a mandated reporter is not bected maltreatment of the ed prior to admission, admitted to the facility from the reporter has reason to adult was maltreated in the ed to report under the ed to report under the facility from the red to report under the facility from the red to report under the facility from the red to report under the facility from the facility from the red to report under the facility from the facility f				

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 68 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		
	30601	B. WING		C 03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SUI	MMIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 5637	9	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
03000 Continued From page	68	03000		
reporter from also repagency.  (e) A mandated report reason to believe that 626.5572, subdivision (5), occurred must masubdivision. If the report ime believes that an investigative agency with determine that the repaccording to the criter subdivision 17, paragreporter or facility may entry point or directly agency information examets the criteria und subdivision 17, paragreporter under subdivision under subdivision under subdivision under subdivision under subdivision when make the report under subdivision when make the report under subdivision u	ter who knows or has an error under section 17, paragraph (c), clause ake a report under this orter or a facility, at any investigation by a lead will determine or should forted error was not neglect in under section 626.5572, raph (c), clause (5), the provide to the common to the lead investigative explaining how the event er section 626.5572, raph (c), clause (5). The increase in the interest of the explaining how the event er section 626.5572, raph (c), clause (5). The increase increase in the interest			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 69 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C  A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE	
SUMMIT RIDGE PLACE		MMIT AVENUE NO APIDS, MN 56379	RTH	
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
03000 Continued From page	e 69	03000		
The findings include:				
confusion, disorienta coordination), alcoho depression.	ded Wernicke's rain disorder that can cause tion, and lack of muscle I induced dementia, and d to the facility on December			
	eceiving services under the a change of ownership 2022.			
The resident's record current service plan.	l lacked evidence of a			
The resident's record lacked evidence of any recent assessments. A progress note entered on August 11, 2022, indicated a 90 day assessment had been completed with no concerns noted. The resident was noted to be jovial and cooperative.				
	l lacked evidence of a use Prevention Plan (IAPP).			
resident's September requested. Progress September 7, 2022 a notes: -September 7, 2022, note entered by regis "Resident to staff altered behavior. Per RA [resident asked for ice very dirty with brown her a clean cup to fill	August 1, 2022, through the r 22, 2022, discharge were notes provided began on and included the following at 8:01 a.m., a behavior stered nurse (RN)-C noted ercation with aggressive sident assistant] staff, e, RAs saw cup she had was water, so staff offered to get and resident attempted to ot in RA's face, began name ushing. Per RA staff,			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 70 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
	1325 SUI	MMIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379	9	
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
03000 Continued From p	age 70	03000		
	very vulgar language such as			
	ıp your cunt." "Go fuck			
-	ou get raped and like it." Staff			
, ,	Ik away in another direction			
	ped following them. Blue stone			
physicians update				
•	22, at 4:01 p.m., a behavior			
_	r call RN-I noted "Resident was			
·	e feed another resident a			
	e. Staff asked her to not feed			
	1] became agitated and			
	ns off the med cart and push			
,	rew the banana peel at the			
	the face and chest. The staff			
•	p the banana peel. As soon as			
•	esident ran up behind the staff ne back of the head. Staff			
	the resident and the resident			
	apartment, slammed the door			
	staff reported the incident to			
	care physician] and verbal			
	call EMS [emergency medical			
	t was transported to ER			
-	for psychiatric evaluation of			
	milies (sic) current wishes are			
that the resident d	oesn't return to the community			
as she is a danger	to other vulnerable adults.			
This was relayed t	o PCP who is working with ER			
LSW [licensed soc	ial worker] to find more			
appropriate placer	nent. No new interventions			
were implemented submitted.	and a MAARC report was not			
	022, at 3:00 a.m., a behavior			
'	RN-C noted, "Resident			
	ne [hospital] with diagnosis of			
	orsGuardian is requesting			
	d remain in her room for meals			
	nen out in the community with			
· ·	guardian is concerned for the			
well-being of staff	and residents within the			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 71 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION	
		A. BUILDING:		
	30601	B. WING		C 03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
SHMMIT DIDGE DI ACE	1325 SU	MMIT AVENUE NO	ORTH	
SUMMIT RIDGE PLACE	SAUK R	APIDS, MN 56379	9	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	O BE COMPLETE
03000 Continued From pag	je 71	03000		
community." No new implemented and a submittedSeptember 22, 202 note entered by RN-discharged and transliving community.  The resident's record completed change of September 13, 2022 the hospital. The assistence of the september 13 and will hit, swear, by resident was noted to history of harming of abusive to staff, and anxious/paranoid or resident was noted to oriented to person, put had no apparent meretain information like able to make safe jut appropriately in soci assessment further in behavioral symptomic physical aggression effective.  The resident's recordinitiated on Septemblisting interventions in was blank with no interventions in the submitted of the submitted of the submitted in the submitted of	winterventions were MAARC report was not  2, at 9:05 a.m., a progress C indicated the resident eferred to a different senior  d contained a partially f condition assessment from the day she returned from the sessment was completed the R1 had a mood disorder tite, and name call. The to have behaviors with a thers, verbally and physically demonstrates suspicious behavior. The to be alert and responsive, blace, time, and situation and mory loss and could recall or the recent events and was degments and function al situations. The indicated the resident had sincluding verbal and and redirection was  d contained a care plan ther 13, 2022. The section for the resident's behaviors terventions listed. The care			
•	sident did not have memory and retain information.			
personnel (ULP)-G s	at 8:50 a.m., unlicensed stated she worked frequently dent had behaviors just very physically abusive			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 72 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
ANDILANC	DI CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED
			D VA/INIC		С
		30601	B. WING		03/21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E, ZIP CODE	
SUMMIT F	RIDGE PLACE	1325 SUN	MIT AVENUE NO	ORTH	
OOMMIT I	AIDOL I LAOL	SAUK RA	APIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFITE DEFICIENCY)	O BE COMPLETE
03000	Continued From page	e 72	03000		
	towards other resident the only interventions redirecting the resident come in and sit with his personally witnessed at least two occasions often have to put them other residents because punch, or throw things other residents were as behaviors had been gould be a more sident altercations to a MAARC report his calm the resident altercations to a MAARC report his residents as well too, to calm the resident diresidents away from his redirect her but that would focus a lot of his other resident. ULP-J behaviors since at least attend she was aware staff member called pher breast. ULP-J stated she was aware staff member called pher breast.	ats and staff. ULP-G stated she was aware of was ant or calling her family to her. ULP-G stated she had R1 push other residents on a ULP-G stated staff would inselves between R1 and her sees he would try to push, at them. ULP-G confirmed afraid of R1 and her noing on for several months. It is a reported the resident to one management but did not erself.  At 9:20 a.m., ULP-J stated it on a nightly basis with that R1 would hit other ULP-J stated they would try nown and keep other her if they weren't able to wasn't always effective. It is targeted one resident and her behaviors towards the stated R1 had been having het November 2021. ULP-J are of a time when another colice after the resident bit the staff member again the ER. ULP-J stated she had done not entia but did not get any difficult or challenging			
	, ,	r in residence (LALDIR)-B			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 73 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		
	30601	B. WING		C <b>03/21/2023</b>
NAME OF PROVIDER OR SUPPI	LIER STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PLACE	1325 SUN	MIT AVENUE N	ORTH	
JOIMINIT RIDGE PLACE	SAUK RA	PIDS, MN 5637	9	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
03000 Continued Fro	m page 73	03000		
to October 202 manipulate oth functioning so stated R1 wou residents and LALDIR-B stat her to calm do her. LALDIR-B after trying to they told her s R1 threw a rei said she was g the police. LAl changed a me much and she	d worked as a ULP from February 22. LALDIR-B stated R1 would her residents and was more high she knew who to target. LALDIR-B ald be aggressive towards staff and would pinch and hit and yell. ted they'd try to redirect R1 or get wan and figure out what triggered a stated R1 was sent to the ER feed another resident and when the couldn't do that, it set her off. mote at a staff members head and going to kill herself so they called LDIR-B stated she knew they edication in the ER but it didn't do wasn't sure what other should be used.			
behavior disturby brain dama brain that cause planning, judge processes) and The resident a 28, 2022, and current license occurred on Judge The resident's current service. The resident's recent assess	admitted to the facility around April began receiving services under the see after a change of ownership une 1, 2022.  record lacked evidence of a plan.  record lacked evidence of any ments.			
	record lacked evidence of a lual Abuse Prevention Plan (IAPP).			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 74 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		30601	B. WING		C <b>03/21/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
SUMMIT	RIDGE PLACE		MMIT AVENUE NO APIDS, MN 56379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
03000	Continued From page	· 74	03000		
	resident's September requested. Progress requested. Progress respetember 4, 2022 are notes:  -September 4, 2022, anote entered by RN-C "resident to staff altered Resident pinched staff draw blood. Resident and threw hard toys a Resident flashing her death on staff as well kill us. Incident witness residents. Intervention room. No further behavior to many the staff altered by RN-C coming out of another offered that she was wassistant] attempted to room, resident was use chest. There were not of incident"  R2's record contained detailing resident to real tercations.  -July 20, 2022, at 3:30 resident altercation was resident to real tercation was resident to real tercation was resident was not reduced. No new interest another observed rubbing and chest. The other resident chest. The other resident resident.	n, resident assisted to her avioral concerns noted at at 8:19 a.m., a behavior conted, "resident was resident's room, staff very mad. RA [resident to redirect resident to her oset and punched RA in the tother witnesses at the time as reported by ULP after R2 vice in the face, leaving little terventions were noted and			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 75 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPP	LIER STREE	ET ADDRESS, CITY, STA	TE, ZIP CODE	
SUMMIT RIDGE PLACE	1325	SUMMIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAU	RAPIDS, MN 5637	9	
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
03000 Continued Fr	m page 75	03000		
the back. No the incident was observed was observed another resident alter went in another resi	new interventions were noted and as not reported to MAARC.  2, at 6:00 p.m., a resident to esident to staff altercation were LP after R2 was observed rubbing ale resident and inappropriately. The male resident was pushing R2 her to go away. When staff 2 became very angry and began f. No new interventions were noted ent was not reported to MAARC. 2, throughout the day, a resident to an was reported by ULP after R2 walking up and down the hallways elling, calling names, in other ms, ripped [staff member's] nail off, bushed [staff member] down the cation was reported by ULP after R2 to be crawling in to bed with ent and "roll on top of her." When d to redirect R2, she punched staff fist to the face. A note was entered August 16, 2022, indicating "no reventions needed." No new were noted and the incident was a MAARC.  2022, at 9:15 p.m., a resident to cation was reported by ULP after R2 are resident's room and pushed her, esident to fall back on the floor. The twas noted to have a small scratch in after the altercation. No new were noted and the incident was noted to have a small scratch in after the altercation. No new were noted and the incident was noted to have a small scratch in after the altercation. No new were noted and the incident was			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 76 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CLIMMIT DIDGE DI AGE	1325 SUM	MIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RAI	PIDS, MN 5637	9	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
03000 Continued From page	· 76	03000		
not stay out of other rebeing asked to leave. hitting staff. No new in the incident was not reacident altercation wouldn't leave her ald threw coffee at R2 and documented "We got R2 keeped (sic) going interventions were no not reported to MAAR-August 27, 2022, at resident and resident reported by ULP after resident's room and be attempting to redirect swearing and grabber and would not let go. noted and the incident MAARC.  September 4, 2022, was reported by ULP member on the arm and september 5, 2022, was reported by ULP another resident's room attempted redirection chest.  An incident report corn september 8, 2022, in 2022, she "took [R2] in showerwhen I went she only allowed ment down before stepping took them off in the slewash her up so we fir	esidents rooms, even after R2 was noted to keep nterventions were noted and eported to MAARC. 5:30 p.m., a resident to as reported by ULP after R2 who was eating dinner and ne. The other resident d R2 hit the resident. Staff [resident] to walk away and at her." No new ted and the incident was CC. 7:45 p.m., a resident to to staff altercation was R2 entered another roke her TV. Staff reported R2 but she kept yelling and d the staff member's wrist No new interventions were t was not reported to a resident to staff altercation after R2 pinched a staff nd drew blood. A resident to staff altercation after R2 came out of m and was very mad. ULP but R2 punched her in the nelected by ULP-G on ndicated on September 7, nto the bathroom for a to help her with her pants, to pulled (sic) them halfway into the shower. She then nower. She wouldn't let me			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 77 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND I LAN OF CONNECTION	ON NOWIDER.	A. BUILDING:		COMIT LETED
		D. VA/INIO		С
30601		B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE	
CLIMANAT DIDOE DI ACE	1325 SUMM	IIT AVENUE N	ORTH	
SUMMIT RIDGE PLACE	SAUK RAP	IDS, MN 5637	9	
(X4) ID SUMMARY STATEMENT OF DEFIC	CIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECED REGULATORY OR LSC IDENTIFYING IN		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
176		140	DEFICIENCY)	
03000 Continued From page 77		03000		
		00000		
dress her or dry her off. Was walking				
bathroom naked, wet, throwing things	, ,			
to rip things off the wall. When I woul out off (sic) the bathroom naked she				
hitting and scratching me. Sister's (si				
called and both said they couldn't cou	,			
didn't know what we want her to do a	•			
Cops were called. [R2] spit on one co	op and hit			
both. [R2] walked out of the bathroon	n with only a			
shirt and wet socks on, so we had to				
other residents in the living room." Fo				
interventions, ULP-G noted she tried	•			
get herself dress (sic), singing our so				
with a towel so we could leave the ba	•			
put everything she could break, throv				
away out of her reach. I gave her spa	•			
called sisters (both). Then police wer				
new interventions were noted and the	e incident			
was not reported to MAARC. The res	sident was			
sent to the emergency room.				
The resident returned from the hospi	tal on			
September 13, 2022. The resident's				
contained a partially completed chan				
condition assessment dated Septem	•			
2022. The assessment was complete	ed remotely			
and had nothing noted for psychologic	•			
behaviors, or cognitive issues. Wand	•			
the only issue checked for behaviora	•			
The resident was not noted to have a	•			
behaviors. No new interventions were place to ensure the safety of other re	•			
R2.	SIGETILS OF			
On March 20, 2023, at 9:00 a.m., UL	P-G stated			
R2 could be in a really great mood th				
flip of a switch, she'd be in a rage. Ul	·			
"I can 100% say yes, the other reside				
scared of her. We got to the point we	e nad to put			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 78 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A BUILDING:	
				С
	30601	B. WING		03/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
	1325 SUI	MMIT AVENUE NO	RTH	
SUMMIT RIDGE PLACE	SAUK RA	APIDS, MN 56379		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	O BE COMPLETE
03000 Continued From pa	ge 78	03000		
other resident's rooman few times R2 was male resident but "fareveryone was ok with MAARC and no other place. ULP-G stated hands up another me "he'd slap her away intervene and redired happening. ULP-G bed with a different or kiss him and that notified but the residence of the couldn't keep of ULP-G stated RDO incidents and she with reports were made ULP-G stated the of included redirection family to come in article.	so she couldn't get into the ms." ULP-G stated there were caught going in to another m and providing oral sex to mily was notified and th it" so it was not reported to er interventions were put in d R2 would try sticking her hale resident's shorts and " and staff would try to eet when they saw it stated R2 would try to climb in male resident, hold his hand, the resident's family was dent was his own person so his were done. ULP-G stated e working with R2 and felt like ther residents safe either. A was notified of all those has not sure if any MAARC regarding R2's behaviors. The interventions they used or calling the resident's violent, they would call the			
both R1 and R2 wo with both residents interventions used i	at 9:20 a.m., ULP-F stated uld have physical altercations and staff. ULP-F stated ncluded sending her to her ecting, and calling family to			
come in and sit with had to be called after room after being dia ULP-F stated police "there was nothing worked in a memory didn't get any other	her. ULP-F stated the police or R2 wouldn't stay in her agnosed with COVID-19. In didn't come as they stated, they could do because I y care unit." ULP-F stated she guidance or direction from thandle either resident's			

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 79 of 82

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED					
				С					
	30601	B. WING		03/21/2023					
NAME OF DOOM DED OF OURDINED	OTDEET AD		TE 710 000E	•					
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STA							
1325 SUMMIT AVENUE NORTH									
		APIDS, MN 5637							
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE					
03000 Continued From pag	e 79	03000							
any training on MAAI she didn't feel like she the end because it wastill had scars on her and hit by R2.	s and could not recall getting RC reporting. ULP-F stated e could care for R2 towards as too dangerous and she arms from being scratched at 9:30 a.m., ULP-J stated								
she'd be great other ULP-J stated R2 wou would go after other stated R2 had some inappropriate behavi and that they had ca	nded on the day, sometimes times everything was wrong. ald hit and pinch staff and residents at times. ULP-J other episodes of or towards other residents ught her giving oral sex to e. ULP-J stated R2 would try er male residents and they								
would tell her no and they were in wheelch ULP-J was not sure in been reported to MA guardian was ok with the police had to be	to stop but she wouldn't and airs so not able to get away. If any of the incidents had ARC but thought since R2's it, it was fine. ULP-J stated called on R2 after she hit she did the same to the								
and R2 returned from any new intervention manage either reside	ULP-J stated when both R1 not get sor new direction on how to ent's behaviors. ULP-J stated mentia but didn't know at she had.								
stated R2 would go for laughing then smack stated if R2 had bad redirect or try activities it wasn't always effect was not sure if any Not submitted for any of the submitt	at 10:45 a.m., LALDIR-B rom 0 to 60, she'd be you in the face. LALDIR-B behaviors, they'd try to es like coloring or music but ctive. LALDIR-B stated she MAARC reports had been the resident to resident -B stated she was not aware								

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 80 of 82

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
			A. BOILDING.		С				
		30601	B. WING		03/21/2023				
NAME OF PROVIDER (	OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE					
1325 SUMMIT AVENUE NORTH									
SUMMIT KIDGE PL	ACE	SAUK RA	APIDS, MN 5637	9					
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE				
03000 Contin	ued From page	e 80	03000						
of any resider the hose or of the hose or other changes not get and was facility resider until the RDO-A assess and R2 conditions and if the hose that's we confirm a restrate been many implements of RD reports history resider.	new intervention the plan of care spital.  rch 21, 2023, at r of operations the if R1 or R2 his prevention plans a sessments to a lot of the red as not sure what record was mere was not at confirmed the ment was not at confirmed the ment was not at confirmed the ment was not at a confirmed the ment was not at a confirmed the ment was a safe ryention used for was different was a safe ryention used for was different was a safe ryention used for both R1 and of resident to refer to a confirmed the facility of	ons or changes to either after they returned from  at 11:15 a.m., regional (RDO)-A stated she was ad service plans, individual as, behavioral assessments, RDO-A stated with the on June 1, 2022, they did cords from the prior owner at had been completed by tated she did not realize the assing those documents at had been completed by tated she did not realize the assing those documents at had been completed provided by the investigator. September 13, 2022, an accurate reflection of R1 dition as both the change in as were completed remotely the was not close to the did using the police as an accurate reflection of R1 dition as both the behavior ety issue. RDO-A confirmed for R1 after her return from a had requested. RDO-A chad not assessed if this was anterventions would have and they had only se family requested they do a was aware of incident and R2 and there was a resident altercations for both ted she was not sure if they MAARC but the facility had	03000						
investi	gations were re	gations. Copies of the equested however RDO-A cument their investigations							

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 81 of 82

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
		A. BUILDING:							
	30601	B. WING		C 03/21/2023					
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE						
CLIMANT DIDOE DI ACE	1325 SUMMIT AVENUE NORTH								
SUMMIT RIDGE PLACE	SAUK R	APIDS, MN 56379							
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE					
03000 Continued From page 81		03000							
and did not have any investigations entailed of the incident reports out. RDO-A confirmed would be reportable become from nursing, nother regional director is nursing. RDO-A confirmed reporter. RDO-A state about readmitting R1 concerns for the other not sure they could be from R1 and R2. RDO report on behalf of the safety concerns were R2 readmitted to the firm R1 and R2. RDO report on behalf of the safety concerns were R2 readmitted to the firm R1 and R2. RDO report on behalf of the safety concerns were R2 readmitted to the firm altered firm and altered firm and any suspected maltred firm and exploitation of assisted living reside incident appears to be or firm and exploitation of firm and exploitation of a services or Communicated for the safety make an altered f	records to show what their d. RDO-A confirmed many swere only partially filled diseveral of the incidents out that direction would of the regional director as a not responsible for rmed she was a mandated ed there were concerns and R2 due to safety residents and they were seep the other residents safe D-A confirmed a MAARC e other residents and their not completed after R1 and facility.  Sulnerable Adult in and federal vulnerable y's employees will report atment (abuse, neglect or of our home care clients ents]." In addition, "if the e suspected abuse, neglect on, the Director of Health ity Director shall oral report to the CEP								

Minnesota Department of Health

STATE FORM NQPG11 If continuation sheet 82 of 82