

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 4, 2024

Licensee Aviva River Bend 30 Silver Lake Place Northwest Rochester, MN 55901

RE: License Number 414973

Health Facility Identification Number (HFID) 31368

Project Number(s) SL31368015

Dear Licensee:

On September 25, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed May 24, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective October 4, 2024.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 24, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on May 24, 2024, found not corrected at the time of the September 25, 2025, follow-up survey and/or subject to a penalty assessment are as follows:

1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) 1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) 1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 1910-Disposition Of Medications-144g.71 Subd. 22

The details of the violations noted at the time of this follow-up survey completed on September 25, 2024, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

Sincerely,

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health Health Regulation Division

Rick Michale

HHH

Minnesota Department of Health

	ND PLAN OF CORRECTION TO IDENTIFICATION NUMBER:		LE CONSTRUCTION :	COMPLETED		
		31368	B. WING		R 09/25/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	•	
	VER BEND	30 SILVEF	R LAKE PLA TER, MN 55	ACE NW		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	Ξ
{0 000}	In accordance with 144G.08 to 144G.9 been issued pursual Determination of whom corrected requires or requirements provide indicated below. Whom contains several iteration of the items will be compliance. INITIAL COMMENT SL31368015-1 On September 23, 2024, the Minnesot conducted a follow-provider to follow-up a survey completed of the survey, there receiving services a Dementia Care lice.	PROVIDER LICENSING DER Minnesota Statutes, section 5 this correction order(s) has ant to a survey. Therefore a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of		Minnesota Department of Health is documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living Facilitiassigned tag number appears in the left column entitled "ID Prefix Tag. state Statute number and the corresponding text of the state State of compliance is listed in the "Sum Statement of Deficiencies" column column also includes the findings are in violation of the state require after the statement, "This Minnesor requirement is not met as evidence Following the evaluators in findings Time Period for Correction. PLEASE DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE STATUTES. THE LETTER IN THE LEFT COLUMN WHICH STATUTES. THE LETTER IN THE LEFT COLUMN WHICH STATUTES. THE LETTER IN THE LEFT COLUMN WHICH STATUTES.	Orders ers have es. The ne far "The atute out mary n. This which ment ota ed by." s is the OING OF OTHIS ON FOR TATE JMN IS ES AND VEL	
{0 480} SS=F	requirements	3) (i) (B) Minimum	{0 480}			
Minnesota Do	epartment of Health					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RIVER BEND 30 SILVER LAKE PLACE NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 480}	Continued From page 1 (13) offer to provide or make available at lefollowing services to residents: (B) food must be prepared and served accepted to the Minnesota Food Code, Minnesota Ruchapter 4626; and This MN Requirement is not met as evidently: No further action required.	ording ules,		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must complete State Fire Code in Minnesota Rules, ch 7511, and: (1) for dwellings or sleeping units, as define the State Fire Code:	ly with lapter ed in n used h cinity ory but attics; n is r s so ns in to g Code, s in		

Minnesota Department of Health

STATE FORM 6899 UHZF12 If continuation sheet 2 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RIVER BEND ROCHEST				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 780}	Continued From page 2 This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.			
{01370} SS=E	(,			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		09/2	₹ 2 5/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE	-	
			R LAKE PLAC			
AVIVA R	IVER BEND		TER, MN 559			
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{01370}	Continued From pa	ge 3	{01370}			
	(iv) dressing and as (6) training on the p (7) standby assistant perform them; (8) medication, exereminders; (9) basic nutrition, rand assistance with (10) preparation of licensed health prof (11) communication the dignity of the resident and the cultural background (12) awareness of (13) understanding between staff and ramily; (14) procedures to emergency situation (15) awareness of (15	esisting with toileting; brevention of falls; ance techniques and how to rcise, and treatment meal preparation, food safety, a eating; modified diets as ordered by a fessional; a skills that include preserving sident and showing respect for e resident's preferences, and family; confidentiality and privacy; appropriate boundaries esidents and the resident's use in handling various ans; and commonly used health ent and assistive devices. The entire is not met as evidenced and record review, the asure training and competency five of five unlicensed ULP-E, ULP-N, ULP-O,				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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(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 APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01370}	Continued From pa	ge 4	{01370}			
	found to be pervasi	ve).				
	The findings include	e:				
		n August 1, 2023, to provide vices to the facility's residents.				
	training for the follow - reports of changes the supervisor design	s in the resident's condition to gnated by the facility; monly used health technology				
	competency evalua	record lacked evidence of tion for appropriate and safe nal hygiene and grooming,				
		n December 18, 2023, to and services to the facility's				
	training for the follow - reports of changes the supervisor design	s in the resident's condition to gnated by the facility; amonly used health technology				
	competency evaluatechniques in persoincluding: - hair care;	record lacked evidence of tion for appropriate and safe nal hygiene and grooming, and oral prosthetic devices; ting.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		31368	B. WING			₹ 25/2024
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLAGE TER, MN 559		•	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
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{01370}	Continued From pa	ge 5	{01370}			
		n November 14, 2023, to and services to the facility's				
	training for the follow - reports of changes the supervisor design	s in the resident's condition to gnated by the facility; nmonly used health technology				
	competency evaluatechniques in personal including: - hair care and bath - care of teeth, gum	record lacked evidence of tion for appropriate and safe anal hygiene and grooming, s, and oral prosthetic devices; se techniques and how to				
		n July 3, 2024, to provide vices to the facility's residents.				
	training for the follow - understanding app	record lacked evidence of wing topics: propriate boundaries between and the resident's family.				
	competency evalua	record lacked evidence of ation for appropriate and safe anal hygiene and grooming,				
		n August 5, 2024, to provide vices to the facility's residents.				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMP	SURVEY
		31368			09/2	₹ 2 5/2024
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{01370}	Continued From pa	ge 6	{01370}			
	competency evaluate techniques in personal including: - hair care and bath - care and use of here are are and use of here are are and use of here are are are are are are are are are	earing aids; sting with toileting; and e techniques and how to 2024, at 11:00 a.m., registered (N/C)-Q stated the ULP as noted above lacked ning and competencies as ndicated they had made mpetency forms a couple of had not had all staff Q further indicated the most had received the required				
	Staff policy dated Jastaff would receiving 4. Training for ULP assistant registered following topics with test: c. Changes in continuous ii. How and n. Appropriate In residents, and residents, and residents, and residents and assistant registered to the state of t	on where to report coundaries between staff, lent families sed health technology				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE						
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{01370}	Continued From page 7	{01370}				
	demonstration: a. Hair care b. Bathing c. Care of teeth, gums, and oral prosthetic devices d. Care and use of hearing aids e. Dressing f. Assisting with toileting g. Standby assistance techniques					
	No further information was provided.					
{01380} SS=E	(.,	{01380}				
	 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. 					
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for five of five unlicensed personnel (ULP-C, ULP-E, ULP-N, ULP-O,					

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	.E CONSTRUCTION	COMPLETED		
		31368	B. WING		09/2	₹ 2 5/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
	VER BEND	30 SILVEF	R LAKE PLA ΓER, MN 559	CE NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01380}	Continued From pa		{01380}			
	violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited numb situation has occurr found to be pervasion. The findings include ULP-C ULP-C was hired or direct care and served care and served training for the follor - observing, reporting status; - basic knowledge of changes in body fur observed changes appropriate personnul ULP-E ULP-E was hired or provide direct care residents. ULP-E's employee training for the follor	ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve). The August 1, 2023, to provide vices to the facility's residents. The record lacked evidence of wing topics: The provide of				
	changes in body fur	of body functioning and netioning, injuries, or other that must be reported to				

	ota Department of Health of Department of Health of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI I	E CONSTRUCTION	(X3) DATE	SURVEY
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	A. BUILDING:		
			A. BOILDING.			
		D 14/11/0		F	₹	
		31368	B. WING		09/2	25/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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AVIVAR	IVER BEND	ROCHES	STER, MN 55 9	01		
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				DEI IOILINOT)		
{01380}	Continued From pa	age 9	{01380}			
	appropriate person	nel				
	appropriate person					
	ULP-N					
	ULP-N was hired o	n November 14, 2023, to				
		and services to the facility's				
	residents.					
	ULP-N's employee	record lacked evidence of				
	training for the follo	owing topics:				
	- observing, reporti	ing, and documenting resident				
	status;					
	 basic knowledge 	of body functioning and				
	changes in body fu	nctioning, injuries, or other				
	observed changes	that must be reported to				
	appropriate person	nel.				
		record lacked evidence of				
	competency evalua					
	- sate transfer tech	niques and ambulation				
	ULP-O					
		n July 3 2024 to provide				
		on July 3, 2024, to provide				
	unect care and ser	vices to the facility's residents.				
	UI P-O's employee	record lacked evidence of				
	training for the follo					

6899

training for the following topics:

- observing, reporting, and documenting resident status;
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel.

ULP-P

ULP-P was hired on August 5, 2024, to provide direct care and services to the facility's residents.

ULP-P's employee record lacked evidence of competency evaluation for: - reading and recording temperature, pulse, and

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If continuation sheet 10 of 18 UHZF12

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
	31368		B. WING		09/2	₹ 5/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
AVIVA R	IVER BEND		R LAKE PLA FER, MN 559			
(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 APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01380}	- range of motioning On September 25, anurse/consultant (Remployee records a evidence of the train required. RN/C-Q is changes to their condifferent times but here-complete. RN/C-recent employees heraining and competed. The licensee's Assistant registered following and receiving 4. Training for ULP assistant registered following topics with test: p. Observing, remaining the proof of the proo	esident; niques and ambulation; and g and positioning; 2024, at 11:25 a.m., registered (N/C)-Q stated the ULP as noted above lacked ning and competencies as indicated they had made impetency forms a couple of had not had all staff Q further indicated the most had received the required tencies. Sted Living Orientation-ULP anuary 30, 2024, indicated g the following training: who are not NAR (nursing and) would receive training in the in a written or oral competency deporting, and documenting and documenting and to appropriate personnel, ining all staff receive, ULP's tered nursing assistant will raining on the following topics all competency test AND a skill of recording temperature, pulse the resident; rechniques and ambulation;	{01380}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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{01380}	Continued From page 11 No further information was provided.	{013	380}		
{01760} SS=E	144G.71 Subd. 8 Documentation of	the st in who entation e, date oute of he so not ance int plan. Enced in the solution of the solution (a alth or ed a ely to	760}		
Minnesota D	was issued at a pattern scope (when more limited number of residents are affected, not than a limited number of staff are involved situation has occurred repeatedly; but is not found to be pervasive).	nore , or the			

Minnesota Department of Health

STATE FORM 6899 UHZF12 If continuation sheet 12 of 18

Minnesota Department of Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R		
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AVIVA RI	VER BEND		R LAKE PLAG TER, MN 559				
			, 				
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				DEFICIENCY)			
{01760}	Continued From pa	ige 12	{01760}				
	•						
	The findings include	∂ :					
	R12						
		dated July 19, 2024, indicated					
	•	stance with medication					
	management.						
	R12's signed presc	riber orders dated July 12,					
	_	taminophen (for mild to					
	• ,	milligrams (mg) 2 tabs every					
	8 hours PRN (as ne	∍eded).					
	Diale Centember 1	0004 through Contombon					
	•	, 2024, through September					
		on administration summary e administration of the					
	following:	3 auministration of the					
		24, (no time documented) PRN					
	•	h no results documented.					
	•	24, (no time documented) PRN					
	· '	h no results documented.					
	•	24, (no time documented) PRN					
	acetaminophen witl	h no results documented.					
	- September 5, 202	24, (no time documented) PRN					
	acetaminophen witl	h no results documented.					
	- September 6, 202	24, (no time documented) PRN					
	•	h no results documented.					
	· '	24, at 9:31 p.m. PRN					
	•	h no results documented.					
	•	024, at 9:59 p.m. PRN					
	•	h no results documented.					
	· ·	024, at 8:56 p.m. PRN					
	•	h no results documented.					
	• '	024, at 12:00 a.m. PRN					
	•	h no results documented.					
		024, at 10:33 p.m. PRN h no results documented					

Minnesota Department of Health

R13

- September 22, 2024, (no time documented) PRN acetaminophen with no results documented.

PRINTED: 10/04/2024

Minnes	ota Department of He	ealth			_	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:	·		
		24200	B WING		R	T /0.0.0.4
	31368				09/25	5/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND	30 SILVI	ER LAKE PLA	CENW		
		ROCHES	STER, MN 55	901		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{01760}	Continued From pa	age 13	{01760}			
	R13 received assist management. R13's signed prescally, 2024, included every 6 hours PRN R13's September 1 24, 2024, MAR Suradministration of the September 2, 202 acetaminophen with September 3, 202 acetaminophen with September 6, 202 acetaminophen with September 6, 202 acetaminophen with September 13, 202 acetaminophen with September 13, 202 acetaminophen with September 13, 202 acetaminophen with September 15, 2	, 2024, through September nmary identified the				

Minnesota Department of Health

R6

acetaminophen with no results documented.

acetaminophen with no results documented.

acetaminophen with no results documented.

- September 19, 2024, (no time documented)

acetaminophen with no results documented.

acetaminophen with no results documented.

acetaminophen with no results documented.

R6's service plan dated August 9, 2024, indicated

PRN acetaminophen with no results documented.

- September 17, 2024, at 8:37 p.m. PRN

- September 18, 2024, at 5:39 p.m. PRN

- September 20, 2024, at 9:01 p.m. PRN

- September 21, 2024, at 9:12 p.m. PRN

- September 23, 2024, at 5:49 p.m. PRN

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		09/2	{ 5/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
AVIVA RIV	ER BEND		R LAKE PLAG TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLETE DATE
{01760}	Continued From pag	ge 14	{01760}			
	R6 received assista nanagement.	nce with medication				
i	ncluded diclofenac apply 2 grams (gm)	ers dated May 7, 2024, sodium 1% gel (for pain), topically twice a day. May ce daily PRN (back pain).				
	2024, MAR Summa of the following: September 21, 20	2024, through September 24, ry identified the administration 24, at 1:44 p.m. PRN gel administered with no				
	nurse/consultant (Reffectiveness was la R6's records as not JLP should have do administration and f	2024, at 1:34 p.m. registered N/C)-Q stated PRN acking from R12, R13, and ed above. RN/C-Q stated the ocumented the time of followed up with the resident cation was given to see if it				
	Treatment and There olicy dated February will provide specific PRN medications controlled the PRN's many matructions will include the provide specific provide the PRN's many matructions will include the provide	rapy Management Services by 20, 2024, included the RN instructions for administering onsistent with the prescriber's reason/circumstances under by be administered. The PRN and the need and interval to effectiveness to the RN.				
i	No further information	on was provided.				
{01910} SS=D	144G.71 Subd. 22 [Disposition of medications	{01910}			
	(a) Any current med	lications being managed by				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		31368	B. WING		09/2	₹ 2 5/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	
AVIVA R	VER BEND		R LAKE PLA ΓER, MN 559			
(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 SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01910}	resident when the remedication manage part of the service president who is decidiscontinued or have disposal. (b) The facility shall remaining with the feexpired or upon the contract or the resident regulations and contract or the resident regulations and contract or the resident regulation including strength, prescription quantity, to whom the date of disposition, individuals involved. This MN Requirement by: Based on interview licensee failed to do record the disposition, individuals involved. This practice results the dosage and data residents (R2). This practice results violation that did not safety but had the president's health or cause serious injury was issued at an isolimited number of real limited number of limited	acility must be provided to the esident's service plan ends or ement services are no longer plan. Medications for a leased or that have been be expired may be provided for dispose of any medications facility that are discontinued or termination of the service dent's death according to state ons for disposition of entrolled substances. In the facility must document in the disposition of the general the medication's name, on number as applicable, the medications were given, and names of staff and other in the disposition. The facility must document in the disposition of the general the medication in the given, and names of staff and other in the disposition. The facility must document in the disposition of the medication including the medication including the for one of three discharged of the medication including the for one of three discharged of the medication of the medication including the formula of the medication of the medication including the formula of the medication of the medication including the formula of the medication of the medication including the formula of the medication of the medication including the formula of the medication of the medication including the formula of the medication including the formula of the medication of the medication including the formula of the medication of the med				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		/ DOILD (O.		R		
	31368	B. WING			5/2024	
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLAG				
	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTI	ON	(VE)	
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
{01910} Continued From pa	age 16	{01910}				
	charged or Deceased Resident lations form identified R2 2024.					
form dated July 15 had columns that is medication/dose/promethod of dispositions signature line. The listed without a dose (supplement) and of Parkinson's);	rescription number, quantity, on/disposal, and a nurse following medications were age: vitamin B-12 carbidopa/l-DOPA (for cation was listed without a					
nurse/consultant (Form laction disposition form laction as noted above and audit. RN/C-Q indicates	2024, at 10:08 a.m. registered RN/C)-Q stated R2's cked the required information d had not been identified in an cated a new form had been he last week to ensure required not missed.					
Medication policy of noted: b. Documentation date, quantity, naminature and signature of with the state of with the state of with the state of the s	osition or Disposal of lated February 20, 2024, of the destruction, listing the le of drug, prescription of person destroying the drugs tness to the destruction must aintained in the resident's s.					
No further informat	ion was provided.					
{02040} 144G.81 Subdivision SS=F physical environme	on 1 Fire protection and ent	{02040}				

Minnesota Department of Health

STATE FORM UHZF12 If continuation sheet 17 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	2
		31368	B. WING		09/2	5/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLA			
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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)	LD BE	(X5) COMPLETE DATE
{02040}	Continued From pa	ge 17	{02040}			
	has a secured dem requirements of sect following additional (1) a hazard vulnerarisk must be performed property. The hazar assessment must be protect the resident (2) the facility shall approved supervise by August 1, 2029.	ability assessment or safety med on and around the ds indicated on the e assessed and mitigated to s from harm; and be protected throughout by an ed automatic sprinkler system				



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 1, 2024

Licensee Aviva River Bend 30 Silver Lake Place Northwest Rochester, MN 55901

RE: Conditional License Number 414973

Health Facility Identification Number (HFID) 31368

Project Number(s) SL31368015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90 day conditional license due to expire on **September 29, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to

Aviva River Bend July 1, 2024 Page 2

Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing** these fines against your license at this time.

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

CONDITIONAL LICENSE ISSUED:

MDH will issue Aviva River Bend a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Aviva River Bend is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. No new substantiated maltreatment allegations: If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- **b. No new admissions:** Aviva River Bend will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Aviva River Bend must provide the Department:
 - A list of the names and birthdates of any individuals Aviva River Bend is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- **Consultant:** Aviva River Bend will contract with an RN to provide consultation concerning all resident(s) to whom Aviva River Bend provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Aviva River Bend. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Aviva River Bend and MDH must review the RN's credentials and approve the selection. Aviva River Bend is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Aviva River Bend in an effort to help Aviva River Bend align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Aviva River Bend will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Aviva River Bend and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Jodi.Johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:

- i. Progress towards correction of orders;
- ii. Observations of staff delivering assisted living services and the level of competency observed;
- iii. Conversations with residents and family members about satisfaction with assisted living services;
- iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
- v. Overall impressions about the quality of the assisted living services delivered;
- vi. Overall impressions about the dignity with which the residents and their family members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Aviva River Bend to correct the violations cited during the survey as well as to determine the overall practice of Aviva River Bend in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- **f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. Corrective Action Plan: Aviva River Bend will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Aviva River Bend is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Aviva River Bend is in substantial compliance on the follow up survey, MDH will remove the conditions from Aviva River Bend's assisted living facility license, and Aviva River Bend will correct any outstanding violations identified during the survey. If Aviva River Bend is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

Aviva River Bend July 1, 2024 Page 5

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

Rick Michals, J.D.

Interim Assistant Division Director

Minnesota Department of Health Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER	o. ` ´	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING:	
31368	B. WING		05/24/2024
NAME OF PROVIDER OR SUPPLIER STR	REET ADDRESS, CITY,	STATE, ZIP CODE	
AVIVA RIVER BEND	SILVER LAKE PLA CHESTER, MN 55		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
0 000 Initial Comments	0 000		
ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, sect 144G.08 to 144G.95, these correction orders issued pursuant to a survey. Determination of whether violations are correquires compliance with all requirements provided at the Statute number indicated betwhen Minnesota Statute contains several ite failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31368015-0 On May 20, 2024, through May 24, 2024, the Minnesota Department of Health conducted intial survey at the above provider, and the following correction orders are issued. At the of the survey, there were 69 residents; 56 receiving services under the provider's Assis Living with Dementia Care license. 2310: An immediate order was identified on 21, 2024, at a level 3/Pattern (H). The imme	ected low. ems, e time sted May diacy	Minnesota Department of Health is documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living Facility assigned tag number appears in the far-left column entitled "ID Prefix Tate Statute number and the corresponding text of the state State of compliance is listed in the "Sum Statement of Deficiencies" column column also includes the findings are in violation of the state require after the statement, "This Minneson requirement is not met as evidence Following the evaluators in findings. Time Period for Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUMN.	Orders ers have les. The leg." The letute out limary in. This which ment ota led by." is is the ON FOR TATE
was lifted on May 23, 2024, but the scope ar level remains unchanged.	10	THE LETTER IN THE LEFT COLU USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	SES AND EVEL
0 250 144G.20 Subdivision 1 Conditions SS=F	0 250		
(a) The commissioner may refuse to grant a Minnesota Department of Health			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minneso	<u>ota Department of He</u>	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMPI	
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
۸\/I\/۸ D	IVER BEND	30 SILVEF	R LAKE PLA	CE NW		
AVIVAR	IVER BEIND	ROCHEST	TER, MN 559	901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	,	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
0 250	Continued From pa	ge 1	0 250			
	provisional license, result of a change if a license, suspend a conditional license individual, or employ facility: (1) is in violation of, license has violated this chapter or adoption (2) permits, aids, or illegal act in the proservices; (3) performs any act safety, and welfare (4) obtains the licental fact in the any other record or chapter; (5) knowingly make material fact in the any other record or chapter; (6) denies representation; (7) interferes with othe department in coresidents; (8) interferes with other department in coresidents; (9) interferes with other department in coresidents; (10) interferes with other department in coresidents; (11) is in violation of, interferes with other department in coresidents; (12) interferes with other department in coresidents; (13) performs any act of interference with other department in coresidents; (14) obtains the licent in the proservices; (15) knowingly make material fact in the proservices; (16) denies representation; (17) interferes with other department in coresidents; (18) interferes wi	refuse to grant a license as a nownership, refuse to renew or revoke a license, or impose if the owner, controlling yee of an assisted living or during the term of the language of the requirements in oted rules; abets the commission of any vision of assisted living at detrimental to the health, of a resident; ase by fraud or so a false statement of a application for a license or in report required by this application				
	the department in the or fails to fully coop	r impedes a representative of ne enforcement of this chapter erate with an inspection, tion by the department;				

Minnesota Department of Health

(10) destroys or makes unavailable any records

or other evidence relating to the assisted living

facility's compliance with this chapter;

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		COMPLETED	
		31368	B. WING		05/	24/2024
	PROVIDER OR SUPPLIER VER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLAGE TER, MN 559			
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0 250	section 144.057 or 2 (12) fails to timely promissioner; (13) violates any local relating to housing of (14) has repeated in performing services level; or (15) has operated by assisted living facility (b) A violation by a cassisted living services by the facility. This MN Requirements by: Based on interview licensee failed to shoof licensure, by attended and/or in and procedures as reviewed. This had residents, staff, and the resident's health or cause serious injury is issued at a wides are pervasive or rephas affected or has portion or all of the The findings included.	te a background study under 245A.04; ay any fines assessed by the cal, city, or township ordinance or assisted living services; acidents of personnel is beyond their competency beyond the scope of the cy's license category. Contractor providing the ces of the facility is a violation and record review, the low they met the requirements sting the managerial officials ay-to-day operations oble statutes and rules; nor implemented current policies required with records the potential to affect all visitors. Bed in a level two violation (and tharm a resident's health or intential to have harmed a safety, but was not likely to ay, impairment, or death), and pread scope (when problems or the potential to affect a large residents).	0 250			
	burning the entrance	conference on May 20, 2024,				

Minnesota Department of Health

STATE FORM UHZF11 UHZF11 If continuation sheet 3 of 104

Minnesota Department of Health

	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED	
		31368	B. WING		05/2	24/2024
	PROVIDER OR SUPPLIER VER BEND	30 SILVE	DRESS, CITY, S R LAKE PLAC TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 250	(LALD)-A stated the charge of the facility assisted living regular provided medication services. The licensee's Appl License, section title Owner or Authorize the application), ide and understand the placed before each I have read and fur [Minnesota] Stat. [s 144G.45, my building subdivisions 1-3 of section Laws 2020, [session]., chpt. [ch 17. I have read and fur sect. 144G.80, 1446 Spec. Sess., chpt. 144G.80, 1446 Spec. Sess., chpt. 144G. Assisted Living Licentral charges and fur sect. 144G.80. Assisted Living Licentral charges applicable. Reporting of Maltral charges and fur sect. 144G. I understand pursuant contains a section Laws 2020.	sed assisted living director elicensee's employees in y were familiar with the lations and the licensee in and treatment management dication for Assisted Living ed Official Verification of dagent, (page five and six of ntified, I certify I have read following: [a check mark was of the following]: Ily understand Minn. tatute] sect. [section] ing(s) must comply with the section, as applicable 7th Spec. [special] Sess apter] 1. art. [article] 6, sect. Ily understand Minn. Stat. G.81. and Laws 2020, 7th I, art. 6, sect. 22, my imply with these sections if the sections if the section of	0 250			
	rigins of Subjects (of Data, the Commissioner will				

Minnesota Department of Health

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	31368	B. WING		05/2	24/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLA FER, MN 559			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
may include an in-pronference, to deterequirements for as understand I am not requested information or the smisleading information of my application of a license. I understand appropriate state, from the commissiones of circumstances appropriate state, from the commissiones of circumstances appropriate state, from the commissiones of circumstances appropriate state, from the circumstance appropriate	ovided in this application, which person or telephone ermine if the applicant meets essisted living licensing. I but legally required to supply the sion; however, failure to provide submission of false or ation may delay the processing or may be grounds for denying than that information submitted er in this application may, in es, be disclosed to the federal or local agency and law to enhance investigative or sor further a public health and Types of offices include Adult of the federal or local agency and law to enhance investigative or sor further a public health and the federal or offices include Adult of the federal or local agency and law to enhance investigative or sor further a public health and the federal or offices include Adult of the federal or offices of the ombudsmen, ards, Department of Human or city attorneys' offices, police,				

Minnesota Department of Health

STATE FORM UHZF11 UHZF11 If continuation sheet 5 of 104

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	24/2024	
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLAGE FER, MN 559		•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
0 250	attachments and chindicating my review Minnesota Statutes related to assisted my knowledge and true, correct, and cowriting, of any chan required. - I attest to have all procedures of Minn Minn. Rules chapte and to keep them compared and to keep them compared and my annuary 31, 202 January 30, 2025. The licensee had an on January 31, 202 January 30, 2025. The licensee failed policies and procedimplemented: (1) requirements in maltreatment of vuluations of staff. (3) conducting initiate evaluations and assincluding assessment appropriate licenses changes in a reside managed, and compared in the care provided (4) orientation to an assisted living bill on (5) conducting appropriate licenses (4) orientation to an assisted living bill on (5) conducting appropriate licenses (4) orientation to an assisted living bill on (5) conducting appropriate licenses (5) conducting appropriate licenses (6) conducting appropriate licenses (7) conducting appropriate licenses (8) orientation to an assisted living bill on (5) conducting appropriate licenses (9) conducting appro	his application and all necked the above boxes of and understanding of the Rules, and requirements iving licensure. To the best of believe, this information is implete. I will notify MDH, in ges to this information as required policies and the Stat. chapter 144G and the 4659 in place upon licensure the urrent as applicable. In assisted living license issued the following ures were developed and/or section 626.557, reporting of the nerable adults; ing, and competency I and ongoing resident sessments of resident needs, and so a registered nurse or display a registered nurse or display and the resident and other is as appropriate; dimplementation of the					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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30 SILVER LAKE PLACE NW

AVIVA RIVER BEND ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 6	0 250		
	Staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and (6) medication and treatment management As a result of this survey, the following orders were issued 0630, 0660, 1370, 1380, 1470, 1620, 1700, 1730, 1760, 1820, 1880, 1910, 1940, 1960 1970, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or	0 470		

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		31368	B. WING		05/2	4/2024
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLAGE TER, MN 559			
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0 470	building, or on a confacility in order to reamount of time; (iii) capable of comic (iv) capable of provappropriate assistant (v) capable of follow. This MN Requirement by: Based on interview licensee failed to enevaluated twice a yestaffing levels. This residents and staff. This practice results violation that did not safety but had the president's health or cause serious injury is issued at a wides are pervasive or rephas affected or has portion or all of the. The findings include The licensee's cension whom received services. During the entrance at 11:15 a.m. the licensee. The licensee's staff.	me building, in an attached atiguous campus with the espond within a reasonable municating with residents; iding or summoning the nce; and wing directions; ent is not met as evidenced and record review, the asure the staffing plan was ear to ensure appropriate had the potential to affect all of the licensee. The din a level two violation (at harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and pread scope (when problems present a systemic failure that the potential to affect a large residents).	0 470			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	31368	B. WING	05/24/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE		

30 SILVER LAKE PLACE NW

I AVIVA RIVER BEND		R LAKE PLA ΓER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 8	0 470		
	the survey start and request of document on May 20, 2024.			
	On May 22, 2024, at 8:44 a.m., licensed assisted living director (LALD)-A stated there had been a recent change in director of nursing and was unable to find evidence the staffing plan had been reviewed twice per year as required.			
	The licensee's undated, Staffing, Direct-Care Staffing Plan & Daily Schedule policy noted the staffing plan would be evaluated for appropriate staffing levels in the facility and revised as needed at a minimum of two times per year.			
	No further information was provided.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		
	(13) offer to provide or make available at least the following services to residents:(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RI	VER BEND ROCHEST			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480		0 480		
	widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 21, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.			
0 580 SS=F	i i i o i i o dibai o diamity i i a i a goi i i o i i	0 580		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	24/2024
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE CE NW		
AVIVA RIVER BEND	ROCHES	TER, MN 559	01		
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0 580 Continued From pa	age 10	0 580			
violation that did no safety but had the resident's health or widespread scope or represent a syst	ted in a level two violation (a of harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected I to affect a large portion or all				
The findings includ	The findings include: On May 20, 2024, at 11:15 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated the licensee had not created or implemented a QMP. The licensee's Quality Management Plan policy dated February 20, 2024, indicated the licensee would develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality services for residents.				
entrance conference director (LALD)-As					
dated February 20 would develop a coand management agency's continuous efforts, consistent standards and the					
No further informat	tion provided.				
TIME PERIOD FO (21) days	R CORRECTION: Twenty-one				
0 630 144G.42 Subd. 6 (SS=E requirements for re	b) Compliance with eporting ma	0 630			
individual abuse pr vulnerable adult. T individualized revie	et develop and implement an evention plan for each he plan shall contain an ew or assessment of the ility to abuse by another				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLA TER, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 11	0 630			
	person's risk of abu and statements of t taken to minimize th	other vulnerable adults; the sing other vulnerable adults; he specific measures to be ne risk of abuse to that person e adults. For purposes of the lan, abuse includes				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for five of five residents (R1, R2, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).					
	The findings include	e:				
		uded dementia (the loss of the ember, and reason to levels and activities).				
	indicated R1 receive grooming/personal toileting, mobility/an	hygiene, dressing, bathing,				

Minnocote Donartment of Health

<u> wiinnes</u>	sota Department of He	eaitn					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31368	B. WING		05/2	4/2024	
NAME O	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
AVIVA RIVER BEND			R LAKE PLA TER, MN 559				
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NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND		STREET ADDRESS, CITY, STATE, ZIP CODE				
		30 SILVER LAKE PLACE NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 630	Continued From page 12	0 6	530			
	R1's Vulnerability and Safety assessment of the Health and Service Evaluation assessment (identified as the IAPP) of October 21, 2023, failed to include: -the person's risk of abusing other vuladults;	on dated				
	In addition, R1's IAPP indicated R1 was be abused. The licensee failed to import interventions to minimize his abuse by including other vulnerable adults.	plement				
	R2's diagnoses included Lewy Body progressive dementia that results from deposits in nerve cells of brain. It affer movement, thinking skills, mood, me behavior), and Parkinson's Disease (the central nervous system that affect movement, often including tremors).	m protein ects mory, and a disorder of				
	R2's service plan dated April 30, 2024 R2 received assistance with dressing toileting, mobility/ambulation, escorts housekeeping, laundry, and medicati management.	g, bathing, s,				
	R2's Vulnerability and Safety assessment of the Health and Service Evaluation assessment (identified as the IAPP) of 30, 2024, failed to include: -the person's risk of abusing other vuladults;	on dated April				
	In addition, R2's IAPP indicated R2 was to be abused. The licensee failed recognize that R2 was a vulnerable a susceptible to abuse/neglect by other Furthermore, the licensee failed to integrate the susceptible of Health	d to adult and was rs.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		31368	B. WING	_	05/24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	
AVIVA RI	IVER BEND		R LAKE PLA TER, MN 559		
(X4) ID PREFIX TAG	/EAGLI DEELGIENIGY/AM IGT DE DDEGEDED DY/ ELILI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XECTION SHOULD BE COMPONENTS) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	
0 630		nimize his abuse by others	0 630		
	•	luded diabetes, congestive muscle doesn't pump blood as nd low back pain.			
	2024, indicated R4 assistance with a b dressing, grooming medication adminis	vice Plan dated March 27, received services including oot and brace, bathing, /personal hygiene, toileting, stration, mobility/ambulation, keeping, and laundry.			

R4's Vulnerability and Safety assessment built into the Health and Service Evaluation assessment (identified as the IAPP) dated March 7, 2024, failed to include:

- the person's risk of abusing other vulnerable adults;

R5

R5's diagnoses included cerebellar ataxia (disorder that affects balance and coordination).

R5's Service Plan dated May 7, 2024, indicated R5 received assistance with continuous positive airway pressure (CPAP) machine (helps an individual to breathe continuously while they sleep), dressing, grooming/personal hygiene, mobility/ambulation, toileting, transferring, housekeeping, and laundry.

R5's Vulnerability and Safety assessment built into the Health and Service Evaluation assessment (identified as the IAPP) dated May 7, 2024, failed to include:

 the person's risk of abusing other vulnerable adults;

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			

AVIVA RIVER BEND		30 SILVER LAKE PLACE NW ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULI REGULATORY OR LSC IDENTIFYING INFORMATION	.L [ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
0 630	Continued From page 14	0	630			
	R6 R6's diagnoses included dementia.					
	R6's Service Plan dated March 9, 2024, ind R6 received assistance with bathing, medic administration, housekeeping, and laundry.	cation				
	R6's Vulnerability and Safety assessment be into the Health and Service Evaluation assessment (identified as the IAPP) dated A 8, 2023, failed to include: - the person's risk of abusing other vulnerable adults;	August				
	On May 23, 2024, at 11:11 a.m., registered (RN)-B stated the risk of abusing other vuln adults was lacking from the residents' IAPP noted above. RN-B further stated R1's IAPP lacked interventions to minimize his abuse to others including other vulnerable adults and IAPP should indicate that he was at risk to be abused and implement interventions to minimize his abuse.	nerable Ps as P by d R2's be				
	The licensee's Individual Abuse Protection Folicy dated February 20, 2024, indicated the IAPP would include: - individualized review or assessment of the resident's susceptibility to be abused by and individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable.	he e other ;				
	 adults; specific measures to minimize the risk of a to that person and other vulnerable adults; measure to minimize the risk of self-abuse applicable. Abuse prevention plans will be reviewed ever days and revised as needed. 	and e, if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	31368	B. WING	05/24/2024	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RIVER BEND		R LAKE PLA ΓER, MN 559	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
0 630	Continued From page 15	0 630	
	No further information was provided.		
	TIME PERIOD FOR CORRECTION: Seven (7) days		
0 660 SS=D		0 660	
	 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. 		
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, for one of two employees (unlicensed personnel (ULP)-E).		
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a		

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED		
		31368	B. WING	_	05/2	24/2024
NAME OF PRO	OVIDER OR SUPPLIER	30 SILVER	DRESS, CITY, S R LAKE PLAGE TER, MN 559			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
ricklinas T T2 Uli Utees Clia Tdpnnv Tgir2easu	cause serious injury vas issued at an iso imited number of real limited number of situation has occurrent for findings included the findings included the facility's TB risk 2024, indicated the JLP-E began provided by the face on December of the Bolder of the ficense on December of the ficense of the ficen	safety, but was not likely to y, impairment, or death), and plated scope (when one or a esidents are affected or one or staff are involved or the ed only occasionally). E: Cassessment dated March 20, licensee was "low risk". ding direct care service for the ber 18, 2023. tained a negative TB blood er 4, 2023; however, ULP-E's cked a TB history and tt 12:10 p.m. licensed assisted D)-A stated ULP-E was lacking	0 660			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

30 SILVER LAKE DLACE NW

I AVIVA RIVER BEND		R LAKE PLA ER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 17	0 660		
	be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."			
	No further information was provided.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
0 690 SS=F	144G.43 Subdivision 1 Resident record	0 690		
	(a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for six of six residents (R1, R2, R4, R5, R6, and R7).			
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).			
	The findings include:			
	R1			
N.4: (5	enartment of Health			

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA TER, MN 559			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 690	Continued From pa	ge 18	0 690			
		uded dementia (the loss of the ember, and reason to levels and activities).				
	indicated R1 receive grooming/personal toileting, mobility/an	ated October 26, 2023, ed assistance with hygiene, dressing, bathing, nbulation, transfers, dry, and medication				
	On May 21, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.					
	R1's Medication Administration Record (MAR) Summary dated May 1, 2024, through May 21, 2024, included staff initials but lacked staff names/signature and credentials/title.					
	R1's Monthly Task Log dated May 1, 2024, through May 21, 2024, included staff initials and name, but lacked staff credentials/title.					
	R1's Health and Service Evaluation assessments dated August 23, 2023, and October 21, 2023, identified the staff name but lacked staff credentials/title.					
	R1's Progress Notes dated September 25, 2023, through March 29, 2024, identified the staff name but lacked staff credentials/title.					
	progressive dement deposits in nerve commovement, thinking	uded Lewy Body Dementia (a tia that results from protein ells of brain. It affects skills, mood, memory, and tinson's Disease (a disorder of system that affects				

Minnesota Department of Health

Willingsola Departificiti of the	zaitti		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE	
AVIVA RIVER BEND	30 SILVEF	R LAKE PLACE NW	

	VER BEND 30 SILVER	R LAKE PLA		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 movement, often including tremors). R2's service plan dated April 30, 2024, indicated R2 received assistance with dressing, bathing, toileting, mobility/ambulation, escorts, housekeeping, laundry, and medication management. On May 21, 2024, at 1:27 p.m., the surveyor observed ULP-C administer medications to R2. R2's MAR Summary dated May 1, 2024, through May 21, 2024, included staff initials but lacked staff names/signature and credentials/title. R2's Monthly Task Log dated May 1, 2024, through May 21, 2024, included staff initials and name, but lacked staff credentials/title. R2's Health and Service Evaluation assessments dated April 30, 2024, identified the staff name but lacked staff credentials/title. R2's Progress Notes dated May 2, 2024, through May 17, 2024, identified the staff name but lacked staff credentials/title.	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	R4's diagnoses included diabetes, congestive heart failure (heart muscle doesn't pump blood as well as it should), and low back pain. R4's unsigned, Service Plan dated March 27, 2024, indicated R4 received services including assistance with a boot and brace, bathing, dressing, grooming/personal hygiene, toileting, medication administration, mobility/ambulation, transferring, housekeeping, and laundry.			
	On May 21, 2024, at 7:12 a.m. the surveyor epartment of Health			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	` '	E SURVEY PLETED
		04000	B. WING			0.4.40.00.4
		31368	D. WING		05/	24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	IVER BEND	30 SILVEF	R LAKE PLA	CE NW		
AVIVAR	IVER BEIND	ROCHES	ΓER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 690	Continued From pa	ge 20	0 690			
	observed ULP-E ch administer his insul	eck R4's blood sugar and in.				
	May 21, 2024, inclu	y dated May 1, 2024, through ded staff initials but lacked ires and credentials/title.				
		og dated May 1, 2024, 24, included staff initials and taff credentials/title.				
	dated September 1	rvice Evaluation assessments 2, 2023, December 6, 2023, identified the staff name but tials/title.				
		uded cerebellar ataxia s balance and coordination).				
	R5 received assistation airway pressure (Claim individual to breathersleep), dressing, gr	lated May 7, 2024, indicated ince with continuous positive PAP) machine (helps an e continuously while they ooming/personal hygiene, toileting, transferring, laundry.				
	observed ULP-K lo	at 12:17 p.m. the surveyor ck R5's wheelchair breaks, d transfer R5 into his recliner				
		og dated May 1, 2024, 24, included staff initials and				

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name, but lacked staff credentials/title.

but lacked staff credentials/title.

R5's Fall Assessments dated December 11,

2023, and May 7, 2024, identified the staff name

Minnesota Department of Health

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER	BEND		R LAKE PLA TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	LD BE	(X5) COMPLETE DATE
0 690 C o	ntinued From pa	ge 21	0 690			
Feb ide	oruary 19, 2024,	and February 16, 2024, and February 24, 2024, ame but lacked staff				
thro	•	s dated December 11, 2023, 24, identified the staff name dentials/title.				
dat	ed December 11	rvice Evaluation assessments , 2023, December 27, 2023, entified the staff name but ials/title.				
R6 R6'	's diagnoses incl	uded dementia.				
R6	received assista	ated March 9, 2024, indicated nce with bathing, medication sekeeping, and laundry.				
		t 7:34 a.m. the surveyor minister medications to R6.				
Ma	y 21, 2024, inclu	y dated May 1, 2024, through ded staff initials but lacked res and credentials/title.				
thro	ough May 21, 20	og dated May 1, 2024, 24, included staff initials and aff credentials/title.				
thro	•	s dated October 25, 2023, 4, identified the staff name but ials/title.				
dat		rvice Evaluation assessment 23, identified the staff name dentials/title.				

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIV	/ER BEND		R LAKE PLA TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 690	Continued From page	ge 22	0 690			
	pressure).	uded hypertension (high blood				
	R7 received assista	administration,				
		t 8:11 a.m. the surveyor minister medications to R7.				
	May 21, 2024, inclu	y dated May 1, 2024, through ded staff initials but lacked res and credentials/title.				
	nurse/consultant (R documents staff sho initials, name, signal each page. RN/C-D health record (EHR) was not set up to in	t 1:49 p.m., registered N/C)-D stated for paper ould have included their ture, and title at the bottom of further stated the electronic system used for all residents clude the staff credentials/title cuments listed above.				
	(RN)-B stated the d	t 11:25 a.m. registered nurse ocuments lacked staff and credentials/titles as noted				
	January 31, 2024, in entries would be leg	dent Records policy dated ndicated resident record jible, permanently recorded, by the person making the				
	No further informati	on was provided.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

30 SILVER LAKE DLACE NW

AVIVA RI	VER BEND	R LAKE PLA FER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 690	Continued From page 23	0 690		
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
0 730 SS=E	Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care			
Minnesota De	epartment of Health			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		LAKE PLA			
AVIVA RIVER BEND	ROCHEST	ER, MN 559	901		
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)	LD BE	(X5) COMPLETE DATE
0 730 Continued From pa	age 24	0 730			
provided as identification (12) documentation and reviewed the according (13) documentation any resolution; (14) a discharge substantiation notice when applicable; according (15) other docume chapter and relevant status. This MN Requiremality: Based on observative review, the license record included the	that services have been ed in the service plan; that the resident has received assisted living bill of rights; nof complaints received and ammary, including service and related documentation, and nation required under this nation to the resident's services or the resident erapired documentation of all for five of five residents (R1,				
violation that did no safety but had the resident's health or cause serious injury was issued at a partimited number of rethan a limited num situation has occur found to be pervase. The findings include R1, R2, R4, R5, and documentation that scheduled.					
R1					

Minneso	ta Department of He	ealth			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		31368	B. WING		05/24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
۸\/I\/۸ D	VER BEND	30 SILVE	R LAKE PLA	CE NW	
AVIVAR	IVER BEIND	ROCHES	STER, MN 559	901	
(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 CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
0 730	Continued From pa	ige 25	0 730		
	R1's diagnoses inc	luded dementia.			
	indicated R1 received grooming/personal toileting, mobility/ar	ated October 26, 2023, ed assistance with hygiene, dressing, bathing, mbulation, transfers, ndry, and medication			
	through May 21, 20 personnel (ULP) do follows: -grooming/personal opportunities; -toileting 80 out of dressing: 27 out of	• •			
	progressive demended deposits in nerve c	luded Lewy Body Dementia (a itia that results from protein ells of brain. It affects a skills, mood, memory, and			

R2's service plan dated April 30, 2024, indicated R2 received assistance with dressing, bathing, toileting, mobility/ambulation, escorts, housekeeping, laundry, and medication management.

behavior), and Parkinson's Disease (a disorder of

R2's Monthly Task Log dated May 1, 2024,

the central nervous system that affects

movement, often including tremors).

through May 21, 2024, identified the unlicensed personnel (ULP) documented the serves as follows:

-mobility/ambulation: 39 out of 61 opportunities;

-escorts: 48 out of 62 opportunities;

	ota Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND DIAN OF CORRECTION INTERCATION NI IMBER:				COMPLETED	
		31368	B. WING		05/24/2024
		31300			03/24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
Δ\/Ι\/Δ Β	IVER BEND	30 SILVE	ER LAKE PLAC	CE NW	
AVIVAIN	IVER BEND	ROCHES	STER, MN 559	01	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLET DATE
0 730	Continued From pa	age 26	0 730		
	-encourage assisti 41 opportunities.	ve hearing devices: 21 out of			
	_	cluded diabetes, congestive muscle doesn't pump blood as	S		
	R4's unsigned Ser 2024, indicated R4 assistance with a key twice weekly, dress grooming/personal medication administration administration.	vice Plan dated March 27, I received services including boot and brace daily, bathing sing daily, toileting and I hygiene three times per day, stration four times daily, n daily, transferring daily, y, and laundry weekly.			
	through May 21, 20 documented the set - grooming/person opportunities; - toileting: one out - dressing: zero out	Log dated May 1, 2024, 024, identified the ULP ervices as follows: al hygiene: one out of 63 opportunities; on: zero out of 21 opportunities			

Minnesota Department of Health

and

R5

- bathing: one out of six opportunities;

- laundry: zero out of three opportunities;

- trash removal: one out of 42 opportunities

R5's diagnoses included cerebellar ataxia

- daily bed making: zero out of 21 opportunities;

(disorder that affects balance and coordination).

R5's Service Plan dated May 7, 2024, indicated

R5 received assistance with continuous positive

airway pressure (CPAP) machine (helps an

individual to breathe continuously while they

sleep) daily, dressing, grooming/personal

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	SURVEY PLETED
	31368	B. WING		05/	24/2024
NAME OF PROVIDER OR SUPPLIE			STATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLAC TER, MN 559			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
0 730 Continued From	page 27	0 730			
toileting three tim	ambulation three times daily, es daily, transferring three times ng daily, and laundry weekly.				
observed ULP-K	, at 12:17 p.m. the surveyor lock R5's wheelchair breaks, and transfer R5 into his recliner				
through May 21, 2 documented the 3 - dressing: 18 out - grooming/perso opportunities; - CPAP: four out - daily bed makin and	k Log dated May 1, 2024, 2024, identified the ULP services as follows: of 42 opportunities; nal hygiene: 20 out of 42 of 21 opportunities; g: 15 out of 21 opportunities; 6 out of 21 opportunities.				
R6 R6's diagnoses in	cluded dementia.				
R6 received assis	dated March 9, 2024, indicated stance with bathing, medication busekeeping, and laundry.				
through May 21, 2 documented the	k Log dated May 1, 2024, 2024, identified the ULP services as follows: t of six opportunities.				
cares were comp	, at 11:55 a.m. ULP-E stated leted but were not consistently P-E indicated all cares be documented.				
	, at 11:32 a.m. registered nurse ULP were not consistent with				

Minnesota Department of Health

documenting the completion of services. RN-B

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

30 SILVER LAKE PLACE NW

AVIVA RI	VER BEND	R LAKE PLA FER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	stated all services provided should be documented as soon as possible after the task is completed or by the end of their shift. The licensee's Resident Records policy dated January 31, 2024, noted the resident record would contain documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTIONS:	0 730		
0 780 SS=E		0 780		

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/2	7/2024
			R LAKE PLA			
AVIVA R	IVER BEND		ΓER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 780	Continued From pa	ge 29	0 780			
		troduced smoke alarms in ay be battery operated;				
	by: Based on observation failed to provide into that complied with father two resident apartmaffect more than a listaff, and visitors. This practice resulted violation that did not safety but had the president's health or cause serious injury was issued at a path limited number of rethan a	at 9:00 a.m., survey staff ith maintenance director tour, MD-H tested the smoke resident apartments and ed the following: ment 109, when the living was tested, the smoke alarm bedroom 1. ment 302, when the smoke a 1 and 2 were tested, the alarm was not activated. installed in the bedrooms and ng area were not all partments 109 and 302. Our interview on May 24, 2024, verified these smoke alarms				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAIVIE OF F	PROVIDER OR SUPPLIER STR	REET ADDRESS, CITY,	STATE, ZIP CODE			
AVIVA RIVER BEND		30 SILVER LAKE PLACE NW				
	RO	CHESTER, MN 55	901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE		
0 780	Continued From page 30	0 780				
	TIME PERIOD FOR CORRECTION: Seven days	(7)				
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800				
	(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds systems, and equipment in a continuous stagood repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance repair program.	te of				
	This MN Requirement is not met as evidence by: Based on observation and interview, the lice failed to provide the physical environment in continuous state of good repair and operation with regard to the health, safety, and well-be the residents. This had the potential to direct affect all residents, staff, and visitors.	ensee a on eing of				
	This practice resulted in a level two violation violation that did not harm a resident's health safety but had the potential to have harmed resident's health or safety) and was issued a widespread scope (when problems are perveror represent a systemic failure that has affect or has the potential to affect a large portion of the residents).	h or a at a asive cted				
	The findings include:					
	On May 24, 2024, at 9:00 a.m., survey staff toured the facility with maintenance director (MD)-H. During the tour, survey staff observed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE	
AVIVA RIVER BEND	30 SILVE	R LAKE PLACE NW	

NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY		
AVIVA RI	VER BEND	30 SILVER LAKE PLANT SILVER LA		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 31	0 800		
	the following: 1. The spring hinges installed on the lab 20-minute fire door leading from the corresident dwelling unit 217 were not work properly, the door did not self-close and latch. All components of a fire door assemust be maintained in proper working on During the facility tour interview on May MD-H verified the spring hinges were not properly and stated the hinges would be 2. The labeled 20-minute fire doors with self-closing hinges were propped open wedges for the second, third, and fourth laundry rooms. 3. Labeled 20-minute fire doors with self-hinges were propped open with kickdow stops for the fitness center, theatre, and room. Fire doors held open by a wedge or doo prohibit the required operation and closi of the door. 4. The exit door near the elevator equipartoom had two holes in the panel. 5. The labeled 45 minute fire door leading main assisted living dining/living area had holes near the top of the door. During the facility tour interview on May MD-H verified the fire doors that were propen and the holes in the doors. 6. Two extension cords were being used the front desk. 7. An extension cord was used for a light third floor puzzle room. 8. Extension cords were used in resident apartments 217, 509, and 517. Extension cords should not be used as a substitute for permanent wiring. Improper extension cords creates a potential fire I During the facility tour interview on May MD-H verified these extension cords were stension cords were supported these extension cords were not with the supported these extension cords were not were not were not work were not were not work were not were not were not work as a substitute for permanent wiring. Improper extension cords creates a potential fire I During the facility tour interview on May MD-H verified these extension cords were not w	ridor into king positively embly rder 24, 2024, of working adjusted. with floor f-closing reature ment for into the ad three 24, 2024, ropped distribution the at in the at a ger use of hazard, 24, 2024, 2		

Minnesota Department of Health

STATE FORM UHZF11 UHZF11 If continuation sheet 32 of 104

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
VER BEND				
(EACH DEFICIENCY MUST BE PREC	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 32		0 800		
used correctly.				
TIME PERIOD FOR CORRECTI days	ION: Seven (7)			
144G.45 Subd. 2 (g) Fire protect environment	tion and physical	0 820		
assisted living facilities that were housing with services establishme chapter 144D prior to August 1, 2 permitted to continue in use provides not constitute a distinct haz existing elements that an authority jurisdiction deems a distinct hazabe corrected. The facility must defacility's records any actions take a correction order, and must sub-	registered as nents under 2021, shall be vided such use ard to life. Any ard to life must ocument in the en to comply with omit to the			
Based on observation and intervialled to provide facilities that we hazard to life. This had the potential affect all residents, staff, and emorphisms affect all residents, staff, and emorphisms practice resulted in a level to violation that did not harm a resident safety but had the potential to have resident's health or safety) and we widespread scope (when problem or represent a systemic failure the or has the potential to affect a land of the residents). The findings include:	riew, the licensee are not a distinct ntial to directly ployees. We violation (a dent's health or eve harmed a was issued at a ms are pervasive nat has affected rge portion or all			
	SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING Continued From page 32 used correctly. TIME PERIOD FOR CORRECT days 144G.45 Subd. 2 (g) Fire protect environment (g) Existing construction or elem assisted living facilities that were housing with services establishm chapter 144D prior to August 1, 2 permitted to continue in use prov does not constitute a distinct haz existing elements that an author jurisdiction deems a distinct haz be corrected. The facility must d facility's records any actions take a correction order, and must sub commissioner for review and ap correction. This MN Requirement is not me by: Based on observation and interv failed to provide facilities that we hazard to life. This had the poter affect all residents, staff, and em This practice resulted in a level t violation that did not harm a resi safety but had the potential to ha resident's health or safety) and v widespread scope (when problet or represent a systemic failure th or has the potential to affect a la of the residents). The findings include:	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 used correctly. TIME PERIOD FOR CORRECTION: Seven (7) days 144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 used correctly. TIME PERIOD FOR CORRECTION: Seven (7) days 144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 32 used correctly. TIME PERIOD FOR CORRECTION: Seven (7) days 144G. 45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue an authority having jurisdiction deems a distinct hazard to life. Any existing elements that an authority having jurisdiction deems and approval prior to corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to corrected. The facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety) and was issued at a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

30 SILVER LAKE PLACE NW

AVIVA RI	VER BEND	R LAKE PLA TER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	toured the facility with maintenance director (MD)-H. During the tour, survey staff observed the following: In the secure dementia care unit, an illuminated exit sign was installed above a door leading to a patio enclosed by a fence. A key-only padlock was installed on the fence gate. In the assisted living building, an illuminated exit sign was installed above a door leading to a resident outdoor space enclosed by a fence. A key-only padlock was installed on the fence gate. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. During the tour interview on May 24, 2024, MD-H verified the installation of these padlocks on the gates and explained the assisted living outdoor space was locked to keep unauthorized people from entering this area. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01370 SS=D		01370		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE	
AVIVA R	IVER BEND		ER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 34		01370		
innesota D	(4) maintenance of a clean and safe environment; (5) appropriate and safe techniques hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prodevices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toile: (6) training on the prevention of falls: (7) standby assistance techniques a perform them; (8) medication, exercise, and treatmoreminders; (9) basic nutrition, meal preparation and assistance with eating; (10) preparation of modified diets as licensed health professional; (11) communication skills that include the dignity of the resident and show the resident and the resident and show the resident and the resident and the family; (12) awareness of confidentiality and (13) understanding appropriate bour between staff and residents and the family; (14) procedures to use in handling we mergency situations; and (15) awareness of commonly used I technology equipment and assistive This MN Requirement is not met as by: Based on interview and record reviet licensee failed to ensure training and was completed for two of two unlice personnel (ULP-C and ULP-E) to increquired content. This practice resulted in a level two Department of Health	esthetic adding; and how to and how to and safety, and of safety, and respect for erences, d privacy; andaries arious health adevices. s evidenced aw, the ad competency and co			

Minnesota Department of Health

	AND BLAN OF CORRECTION INTERCATION NUMBER:		` ´			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		31368	B. WING		05/2	4/2024	
NAME OF PROVIDE	R OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
AVIVA RIVER BI	END	30 SILVEF	R LAKE PLA	CE NW			
AVIVAINIVEIND		ROCHEST	ER, MN 559	901			
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
01370 Conti	nued From pa	ge 35	01370				
violati safety reside cause was is limited a limit situat. The fit ULP-0 direct. ULP-0 training report of the summand and an equip. ULP-0 composition of the summand and an equip. ULP-0 composition of the summand and an equip. ULP-0 composition of the summand and an equip.	on that did not but had the pent's health or serious injury sued at an isted number of reled number of ion has occurred and service and service and service of changes appropriate and asserve asserve and asserve	tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and polated scope (when one or a residents are affected or one or staff are involved, or the red only occasionally). The August 1, 2023, to provide vices to the facility's residents. The record lacked evidence of wing topics: puirements for all services in the resident's condition to gnated by the facility; clean and safe environment all preparation, food safety, in eating diffied diets as ordered by a	01370				
bathir	ng.	g care and					

Minnesota Department of Health

ULP-E was hired on December 18, 2023, to provide direct care and services to the facility's

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
			R LAKE PLA			
AVIVA R	IVER BEND		TER, MN 559			
(V 4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTI	ON.	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01370	Continued From pa	ge 36	01370			
	residents.					
	ULP-E's employee	record lacked evidence of				
	training for the follo	•				
		uirements for all services				
	provided;	in the resident's condition to				
		gnated by the facility;				
	•	clean and safe environment;				
	-preparation of mod	dified diets as ordered by a				
	licensed health pro	•				
		propriate boundaries between				
		and the resident's family;				
	equipment and ass	monly used health technology				
	equipment and ass	istive devices,				
	ULP-E's employee	record lacked evidence of				
	competency evalua	ition for appropriate and safe				
	•	onal hygiene and grooming,				
	including:					
	- hair care;	ns, and oral prosthetic devices;				
	- care and use of he	•				
	- assisting with toile					
		at 11:06 a.m., registered nurse				
		-C and ULP-E's record lacked				
		ove training and competencies				
	as required.					
	The licensee's Assi	sted Living Orientation-ULP				
		anuary 30, 2024, indicated				
		g the following training:				
	_	who are not NAR (nursing				
	_	d) would receive training in the				
		n a written or oral competency				
	test: b. Documentati	on requirements for services				

Minnesota Department of Health

provided

c. Changes in condition

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

O1370 Continued i. d. Mainter e. Approphygiene ar g. Basic m h. Meal pr i. Food sa j. Assistant k. Preparaticensed fr n. Appropresidents, o. Common and assistant No further TIME PER (21) days O1380 SS=D 144G.61 Sunlicensed (b) In add competer	AVIVA RIVER BEND ROCHEST			
i. d. Mainter e. Approphygiene a g. Basic mh. Meal pri. Food sa j. Assistar k. Preparalicensed mand assistant and	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
d. Mainter e. Approp hygiene a g. Basic n h. Meal pr i. Food sa j. Assistar k. Prepara licensed h n. Approp residents, o. Commo and assist No further TIME PER (21) days 01380 SS=D 144G.61 S unlicense (b) In add competen	ontinued From page 37	01370		
SS=D unlicense (b) In add competen	i. observation ii. How and where to report . Maintenance of a clean and safe environment . Appropriate and safe techniques in personal ygiene and grooming . Basic nutrition . Meal preparation Food safety Assistance with eating . Preparation of modified diets as ordered by a censed health professional . Appropriate boundaries between staff, esidents, and resident families . Commonly used health technology equipment and assistive devices In further information was provided. IME PERIOD FOR CORRECTION: Twenty-one			
competen	44G.61 Subd. 2 (b) Training and evaluation of nlicensed personn	01380		
(1) observed (2) basic leading (3) reading (4) recognant development (5) safe to	o) In addition to paragraph (a), training and ompetency evaluation for unlicensed personnel roviding assisted living services must include: 1) observing, reporting, and documenting esident status; 2) basic knowledge of body functioning and hanges in body functioning, injuries, or other bserved changes that must be reported to ppropriate personnel; 3) reading and recording temperature, pulse, and respirations of the resident; 4) recognizing physical, emotional, cognitive, and developmental needs of the resident; 5) safe transfer techniques and ambulation; 6) range of motioning and positioning; and			

Minnesota Department of Health

AND DIANIOE CORRECTION TO IDENTIFICATION NI IMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	24/2024	
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEI	DRESS, CITY, S R LAKE PLAC				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (ENCY)	OULD BE	(X5) COMPLETE DATE	
This MN Requirements by: Based on interview licensee failed to en was completed for the personnel (ULP-C arequired content.) This practice results violation that did not safety but had the president's health or cause serious injury was issued at an isolimited number of real limited number of situation has occurred. The findings included ULP-C ULP-C was hired or direct care and served. ULP-C's employee training for the follow-observing, reporting status; -basic knowledge of changes in body fur observed changes to appropriate personnul.	edications or treatments as ent is not met as evidenced and record review, the asure training and competency two of two unlicensed and ULP-E) to include all ed in a level two violation (a tharm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death) and olated scope (when one or a esidents are affected or one or staff are involved, or the red only occasionally). e: August 1, 2023, to provide vices to the facility's residents. record lacked evidence of wing topics: g, and documenting resident f body functioning and actioning, injuries, or other that must be reported to					

Minneso	<u>ita Department of He</u>	ealth				
AND PLAN OF CORRECTION TO IDENTIFICATION NITIMBER:		` ′	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			7 N. BOILBING.			
		31368	B. WING		05/2	24/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	TATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLAC STER, MN 559			
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01380	Continued From pa	ige 39	01380			
	training for the followard changes in body further training for the followard for th	ng, and documenting resident of body functioning and nctioning, injuries, or other that must be reported to				
	(RN)-B stated ULP-	at 11:06 a.m., registered nurse -C and ULP-E's record lacked ove training and competencies				
	Staff policy dated J staff would receivin 4. Training for ULP assistant registered following topics with test:	isted Living Orientation-ULP anuary 30, 2024, indicated g the following training: who are not NAR (nursing d) would receive training in the h a written or oral competency eporting, and documenting				

q. Basic knowledge of

i. Body functioning

ii. Changes in body functioning iii. Injuries or other observed changes

that must be reported to appropriate personnel

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

SS=F

01470 144G.63 Subd. 2 Content of required orientation

(a) The orientation must contain the following topics:

01470

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Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
NAME OF DROVIDED OR SLIDDLIED	STREET AD	DRESS CITY STATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	RUCHES	TER, MN 559	01	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
TAG 01470	•	TAG 01470	CROSS-REFERENCED TO THE APPROPRIATE	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	24/2024
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLAGE FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01470	and how it manifest the challenges it po (2) health impacts rage-related hearing incidence of demensiolation, and depre (3) information about that may enhance of involvement, includ assistive listening dand tactile alerting dand direct care and services. This practice results violation that did not safety but had the president's health or cause serious injury was issued at a wide problems are pervaluate that has affer a large portion or alerting dand dand dand dand dand dand dand da	of age-related hearing loss is itself, its prevalence, and ses to communication; elated to untreated loss, such as increased itia, falls, hospitalizations, ession; or at strategies and technology communication and ing communication strategies, evices, hearing aids, visual devices, communication and closed captions. The is not met as evidenced and record review, the issure two of two employees nel (ULP)-C and ULP-E) at to assisted living facility ents and regulations before ed in a level two violation (at harm a resident's health or iotential to have harmed a safety, but was not likely to y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the residents).	01470			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	31368	B. WING	05/24/2024			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
20 SILVED LAKE DLACE NIM						

30 SILVER LAKE PLACE NW

00 O.L.L.	,, .	
ROCHEST	TER, MN 559	901
S	ID	PROVIDER'S PLAN OF CORRECTIO

AVIVA RIVER BEND ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01470	Continued From page 42	01470			
	following required orientation content: - an overview of Assisted Living statues; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - review of the types of assisted living services the employee will be providing and the facility's category of licensure.				
	ULP-E ULP-E was hired on December 18, 2023, to provide direct care and services to the facility's residents.				
	ULP-E's employee record did not include the following required orientation content: - an overview of Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff				

Minnesota Department of He	ealth				
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	31368	B. WING		05/2	4/2024
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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER BEND	30 SILVE	R LAKE PLA	CE NW		
AVIVATRIVER BEITE	ROCHES	TER, MN 55	901		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIL	DATE
01470 Continued From pa	age 43	01470			
responsibilities rela	ated to ensuring the exercise				
and protection of the	•				
I	person-centered planning and				
	d how they apply to direct				
1	rovided by the staff person;				
	ents' complaints, reporting of				
	nere to report complaints,				
- ·	on on the Office of Health				
Facility Complaints	• ';				
- consumer advoca	acy services of the Office of				
Ombudsman for Lo	ong-Term Care, Office of				
Ombudsman for M	ental Health and				
Developmental Dis	abilities, Managed Care				
Ombudsman at the	e Department of Human				
	nanaged care advocates, or				
	ocacy services; and				
1	s of assisted living services				
	e providing and the facility's				
category of licensu	re.				
0 14 00 0004					
	at 9:54 a.m., licensed assisted				
,	D)-A stated ULP-C and				
	cked the required orientation				
	rther stated the owners were				
	e' orientation requirements and				
	he required Minnesota				
orientation training	iui aii Staff.				

Minnesota Department of Health

following topics:

assisted living services

protection of those rights

The licensee's Assisted Living and Assisted Living

dated January 30, 2024, indicated all employees

a. An overview of Minnesota's assisted living law

b. An introduction and review of agency policies

with Memory Care Orientation-All Staff policy

would complete orientation to include the

and procedures related to the provision of

e. The assisted living bill of rights and staff

responsibilities to ensuring the exercise and

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RI	VER BEND	R LAKE PLAG TER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 44	01470		
	j. Principles of person-centered planning and service delivery and how they apply to direct support services k. Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure l. Maltreatment of vulnerable adults m. How to report maltreatment of vulnerable adults n. How to report a crime o. Complaint process			
01620 SS=E	(c) Resident reassessment and monitoring must	01620		
	be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		31368	B. WING		05/2	4/2024
	PROVIDER OR SUPPLIER	30 SILVER	ORESS, CITY, S R LAKE PLACE TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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)	LD BE	(X5) COMPLETE DATE
01620	9, clauses (1) to (5) individualized initial and preferences. The completed within 30 services. Resident be conducted as not the needs of the residendar days from (e) A facility must in of the availability of long-term care consistent acility or the date of resident moves in, which is the service of the licenses of two residents (R2 reassessment within of two residents (R2 reassessments that four of four resident addition, the licenses of condition assess (R5) with multiple father than a limited number of resident's health or cause serious injury was issued at a pat limited number of rethan a limited number	n section 144G.08, subdivision, the facility shall complete an review of the resident's needs he initial review must be calendar days of the start of monitoring and review must seded based on changes in sident and cannot exceed 90 the date of the last review. form the prospective resident and contact information for sultation services under prior to the date on which a trexecutes a contract with a n which a prospective whichever is earlier. The is not met as evidenced on, interview, and record failed to ensure the note of admission for two 2, R5) and ongoing resident and days of admission for two 2, R5, R4, R6, R1). In the failed to complete change ment for one of one resident alls. The interview is earlier of the failed to complete change ment for one of one resident alls. The interview is earlier of the failed to complete change ment for one of one resident alls.	01620			

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
l		31368	B. WING	05/24/2024
	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY STATE ZIP CODE	

	VER BEND 30 SIL	VER LAKE PLAGESTER, MN 559	CE NW	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 46	01620		
	The findings include:			
	R2 R2 began receiving assisted living services on April 30, 2024.			
	R2's Service Plan dated April 30, 2024, indicate R2 received assistance with dressing, bathing, toileting, mobility/ambulation, escorts, housekeeping, laundry, and medication management.	ed		
	R2's record included a Health and Service Evaluation assessment (identified as a "move-in assessment) dated April 30, 2024. R2's record lacked evidence of a 14-day comprehensive nursing assessment.	n"		
	R5 R5 began receiving assisted living services on December 11, 2023.			
	R5's Service Plan dated May 7, 2024, indicated R5 received assistance with continuous positive airway pressure (CPAP) machine (helps an individual to breathe continuously while they sleep), dressing, grooming/personal hygiene, mobility/ambulation, toileting, transferring, housekeeping, and laundry.			
	R5's record included a Health and Service Evaluation assessment (identified as a "move-in assessment) dated December 11, 2023, and a Health and Service Evaluation assessment (identified as 14-day assessment) dated December 27, 2023. The 14-day assessment was 16 days from the date of the move-in assessment, exceeding 14 calendar days.	n"		

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA TER, MN 559			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 4 7	01620			
	In addition, R5's red Service Evaluation 2024. The May 7, 2 days from the last d	cord included a Health and assessment dated May 7, 2024 assessment was 132 late of the assessment on 8, exceeding 90 calendar days.				
	2024, indicated R4 assistance with a body dressing, grooming medication administration	vice Plan dated March 27, received services including bot and brace, bathing, /personal hygiene, toileting, tration, mobility/ambulation, keeping, and laundry.				
	Evaluation assessments 2023, December 6, The March 7, 2024,	d Health and Service nents dated September 12, 2023, and March 7, 2024. assessment was 92 days f the assessment, exceeding				
	R6 received assista	ated March 9, 2024, indicated nce with bathing, medication sekeeping, and laundry.				
	Evaluation assessment R6's record lacked	d a Health and Service nent dated August 8, 2023. evidence of additional sing assessments after the sessment had been				
	indicated R1 receive grooming/personal toileting, mobility/an	hygiene, dressing, bathing,				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMP	LETED
		31368	B. WING		05/2	4/2024
	PROVIDER OR SUPPLIER VER BEND	30 SILVE	DRESS, CITY, S R LAKE PLA TER, MN 559			
(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 SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 48	01620			
	Evaluation assessment and October 21, 20, evidence of addition assessments after the assessment had be on May 23, 2024, at (RN)-B stated the at were late. RN-B further	d a Health and Service nents dated August 23, 2023, 23. R1's record lacked hal comprehensive nursing the October 21, 2023, een completed. It 11:16 a.m. registered nurse bove named assessments of the stated she was behind and trying to get them				
		ecember 11, 2023, with ellar ataxia (disorder that				
	observed ULP-K loc	t 12:17 p.m. the surveyor ck R5's wheelchair breaks, d transfer R5 into his recliner				
	R5 received assista airway pressure (CF grooming/personal	ated May 7, 2024, indicated nce with continuous positive PAP) machine, dressing, hygiene, mobility/ambulation, g, housekeeping, and laundry.				
	dated May 7, 2024, dependent on staff mobility/ambulation assistance with transposition, had three days, and was a high	needs, required extensive sfers and or changes in or more falls in the last 90				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE (COMPL	
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u>, </u>	
4)/I)/A DI)/ED DEND		R LAKE PLA			
AVIVA RIVER BEND	ROCHEST	TER, MN 559	901		
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 SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDER'S PLAN OF CORRECTION SHOUL (PROVIDER'S PLAN OF CORRECTION SHOULD (PROVIDER'S PLAN OF CORRECTION	.D BE	(X5) COMPLETE DATE
01620 Continued From pa	ige 49	01620			
the following: -January 22, 2024, included: Resident weekend, the first obathroom, denies in Resident did break and brought him a resident fell ambula (incontinent garme been bare footed, a provided, and resident here was no incident of the continent was no incident of the continent was bedroom. Resident self-transferring to way. No injuries. completed, and no cause was identified. - January 30, 2024 included: Resident of the continent of the	1:30 p.m. R5's progress note had two falls over the one Friday in the evening in his nitting his head, no injuries. his walker. Family notified new walker. Sunday morning ating trying to get a dependent) out. Each fall resident has a pair of gripper socks lent reminded to use them. ent report on either fall. 9:15 a.m. R5's progress note ed nursing at 6:00 a.m. to a found on the floor in his at stated that he was the bathroom and fell on the There was no incident report new interventions or root				

Minnesota Department of Health

- February 10, 2024, at 3:39 p.m. progress note

Minnesota Department of Health

31368 B. WING 05/24/2	
31300	1/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 SILVER LAKE PLACE NW ROCHESTER, MN 55901	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
included: staff called on call to inform nursing that resident had fallen. Resident was found in a sitting position, R5 stated he was going to self-transfer but when he was going to get up from his recliner, he slid out and landed on the floor. No injuries. There was no incident report completed, and no new interventions or root cause was identified. - February 16, 2024, at 1:27 a.m. incident form noted: R5 was found on the floor at the end of his bed. Resident had gone to bathroom, was "looking for his daughter on the couch," and got tired. Denied hitting head, no bleeding, denies pain, able to move arms and legs. Resident assisted back to bed. Immediate action taken noted: no immediate action taken noted: no immediate action taken. A progress note was noted on February 17, 2024, at 10:10 a.m. which identified the above incident. No new interventions or root cause was identified. - February 19, 2024, at 3:30 p.m. incident form noted: R5 was found sitting on the floor by his chair. Resident stated he was trying to go to the bathroom. Immediate action taken: measured vital signs, staff assisted. No injuries or concerns. A progress note was noted on February 22, 2024, at 11:07 a.m. which identified the above incident. No new interventions or root cause was identified. -February 24, 2024, at 2:15 a.m. incident form noted: R5 was found yelling and laying on the floor located in his bedroom next to his bed. Resident stated he was trying to wake up his wife and that she was sitting in his chair. Resident assisted to standing position and then seated in his recliner. Small skin tear on left arm near elbow and right tig below knee. Reminded	

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE	
		31368	B. WING		05/2	4/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA			
			ER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	LD BE	(X5) COMPLETE DATE
01620	Continued From page	ge 51	01620			
	Immediate action ta standing position, b assisted. A progres 27, 2024, at 12:56 p	onfused and hallucinating. ken: assisted person to andaged, cleansed area, staff is note was noted on February o.m. which identified the above terventions or root cause was				
	(RN)-B stated the d longer employed) have reviewing falls. RN- should be complete interventions to previdentified. RN-B fur	vent future falls should be ther stated there was no root dentified, and no interventions				
	of Residents policy indicated: 1. A RN will complete comprehensive nurse resident's physical, as required: a. Pre-Admissi b. 14-day asset 14-days after start of c. Ongoing asset periodically but no least to the complete start of the comprehensive nurse resident's physical, as required: a. Pre-Admissi b. 14-day asset periodically but no least periodically periodically but no le	sing assessments of the mental, and cognitive needs on Assessment ssment: completed up to				
	Fall Risk policy date the event of a fall: 7. An incident report electronic health recommendate.	Management and Managing ed January 26, 2024, noted in the completed in the cord. This includes the entire fall, and staff will attempt to se of the fall.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RIVER BEND

30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

AVIVA RIVER BEND ROCHESTER, MN 55901				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Continued From page 52	01620			
No further information provided.				
TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650			
(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:				
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days 144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the residents condition, including identification of and information as to who has authority to sign for the resident under those chapters. This MN Requirement is not met as evidenced	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	E CONSTRUCTION	COMP	PLETED
		31368	B. WING		05/2	24/2024
AVIVA RIVER BEND			PRESS, CITY, S R LAKE PLACE ER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01650	licensee failed to enthe required content R2, R4, R5, R6). This practice resulted violation that did not safety but had the president's health or cause serious injury is issued at a wides are pervasive or rephas affected or has portion or all of the The findings include R1 R1's diagnoses included R1 received grooming/personal toileting, mobility/and housekeeping, laund management. R2 R2's diagnoses included R2 R2's diagnoses included R3 received grooming/personal toileting, mobility/and housekeeping, laund management. R2 R2's diagnoses included R3 received grooming/personal toileting, mobility/and housekeeping, laund management. R2 R2's diagnoses included grooms in the central nervous movement, often in the central nervous movement.	and record review, the asure the service plan included to for five of five residents (R1, ed in a level two violation (at harm a resident's health or obtential to have harmed a safety, but was not likely to y, impairment, or death), and pread scope (when problems bresent a systemic failure that the potential to affect a large residents). E: uded dementia. ated October 26, 2023, ed assistance with hygiene, dressing, bathing, anbulation, transfers, dry, and medication uded Lewy Body Dementia (atia that results from protein ells of brain. It affects skills, mood, memory, and chison's Disease (a disorder of system that affects cluding tremors).	01650			
	R2 received assistated toileting, mobility/an	ated April 30, 2024, indicated ince with dressing, bathing, nbulation, escorts, dry, and medication				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMI	PLETED
		31368	B. WING	_	05/	24/2024
	PROVIDER OR SUPPLIER VER BEND	30 SILVER	DRESS, CITY, S R LAKE PLA FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01650	heart failure (heart well as it should), and R4's unsigned, Service R4 assistance with a bed dressing, grooming, medication administransferring, houseld R5's diagnoses includisorder that affect R5's Service Plan de R5 received assistation administration, to letting, transferring R6 R6's diagnoses includieting, transferring R6 R6's diagnoses included R6's Service Plan de R6's diagnoses included R6's Service Plan de R6's diagnoses included R6's diagnoses included R6's Service Plan de R6's Service Plan de R6's diagnoses included R6's Service Plan de R6's diagnoses included R5's diagnoses included R6's diagnoses included R6's diagnoses included R5's diagnoses included R6's	luded diabetes, congestive muscle doesn't pump blood as nd low back pain. vice Plan dated March 27, received services including oot and brace, bathing, /personal hygiene, toileting, tration, mobility/ambulation, keeping, and laundry. luded cerebellar ataxia is balance and coordination). lated May 7, 2024, indicated ance with continuous positive PAP) machine, dressing, hygiene, mobility/ambulation, g, housekeeping, and laundry. luded dementia. lated March 9, 2024, indicated ance with bathing, medication sekeeping, and laundry. d R6's service plans lacked: methods of monitoring eresident; methods of monitoring staff and in that includes: aken if the scheduled service	01650			
		a motified to contact the				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 SILVER LAKE PLACE NW ROCHESTER, MN 55901 UMAI DI REGULATORY OR LOC LIBERTIFYING INFORMATION) PREFIX TAGS Continued From page 55 facility, (iii) the names and contact information of persons the resident wishes to have notified in an emergency in the residents. On May 23, 2024, at 12:31 p.m., licensed assisted living director (LALD)-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan lacked for all residents. The licensee's undated, Contents of Service Plans policy noted the service plan mould include the schedule and methods of monitoring reviews or assessments of the resident, the schedule and method of monitoring staff providing services, and a contingency plan that includes: - action taken if the scheduled service cannot be provided; - information and method to contact the facility names and contact information of persons the resident wishes to have notified in an emergency; - icerumstances in which emergency medical		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	PLETED
AVIVA RIVER BEND 30 SILVER LAKE PLACE NW ROCHESTER, MN 55901 DATE OF TAG ROCHESTER, NN 55901 SUMMARY STATEMENT OF DEFICIENCIES PLAN OF CORRECTION REPORT OF LAKE PLAN OF CORRECTION REPORT OF LAKE PLAN OF CORRECTION REPORT OF LAKE PLAN OF CORRECTION RECOLLATORY OR LSC IDENTIFYING INFORMATION) O1650 Continued From page 55 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident under those consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On May 23, 2024, at 12:31 p.m., licensed assisted living director (LALD)-A stated the service plan lacked the above required content. In addition, LALD-A stated the same format was utilized for all residents. The licensee's undated, Contents of Service Plans policy noted the service plan would include the schedule and method of monitoring reviews or assessments of the resident, the schedule and method of monitoring statip providing services, and a contingency plan that includes: - action taken if the scheduled service cannot be provided; - information and method to contact the facility; - names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition; - identification of and information on who has authority to sign for the resident in an emergency;			31368	B. WING		05/2	24/2024
PRÉFIX TAG O1650 Continued From page 55 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse chapters. On May 23, 2024, at 12:31 p.m., licensed assisted living director (LALD)-A stated the service plan lacked the above required content. In addition, LALD-A stated the service plan solicy noted the service plan would include the schedule and methods of monitoring reviews or assessments of the resident, the schedule and method of monitoring staff providing services, and a contingency plan that includes: - action taken if the scheduled service cannot be provided: - information and method to contact the facility; - names and contact information on persons the resident wishes to have notified in an emergency; - names and contact information on who has authority to sign for the resident in an emergency; - names and contact information on who has authority to sign for the resident in an emergency; - identification of and information on who has authority to sign for the resident in an emergency; - identification of and information on who has authority to sign for the resident in an emergency; - identification of and information on who has authority to sign for the resident in an emergency;			30 SILVER	R LAKE PLAG	CE NW		
facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 1458 and 145C, and declarations made by the resident under those chapters. On May 23, 2024, at 12:31 p.m., licensed assisted living director (LALD)-A stated the service plan lacked the above required content. In addition, LALD-A stated the same format was utilized for all residents. The licensee's undated, Contents of Service Plans policy noted the service plan would include the schedule and methods of monitoring reviews or assessments of the resident, the schedule and method of monitoring services, and a contingency plan that includes: - action taken if the scheduled service cannot be provided; - information and method to contact the facility; - names and contact information of persons the resident wishes to have notified in an emergency; - names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition; - identification of and information on who has authority to sign for the resident in an emergency;	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDED TO THE APPROXIMATION OF THE APPROXIMATI	JLD BE	COMPLETE
	01650	facility; (iii) the names and the resident wishes emergency or if the change in the reside identification of and authority to sign for and (iv) the circumstant medical services are consistent with change chapters. On May 23, 2024, a assisted living direct service plan lacked In addition, LALD-A utilized for all resided. The licensee's undared living policy noted to the schedule and mor assessments of the method of monitorinal and a contingency provided; - information are facility; - names and contingency; - names and contingenc	contact information of persons to have notified in an re is a significant adverse ent's condition, including information as to who has the resident in an emergency; ses in which emergency e not to be summoned oters 145B and 145C, and by the resident under those of the service plan would include the above required content. Stated the same format was ents. Atted, Contents of Service the service plan would include the service plan would include the thods of monitoring reviews the resident, the schedule and the staff providing services, the scheduled service cannot and method to contact the entact information of persons to have notified in an entact information of persons to have notified if there is a change in the resident's of and information on who has the resident in an emergency;				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RI	VER BEND	R LAKE PLAGER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 56	01650		
	services are not to be summoned;			
	No further information was provided.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
01700 SS=F		01700		
	 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced 			
Minnesota D	epartment of Health			

Minnesota Department of Health

STATE FORM If continuation sheet 57 of 104 6899 UHZF11

Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31368	B. WING		05/2	4/2024
	ROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLA FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLETE DATE
	review, the licensee registered nurse (R medication manage all required content R2, R4, R6) prior to management service. This practice results violation that did not safety but had the president's health or cause serious injury was issued at a wid problems are pervafailure that has affect a large portion or all. The findings include During the entrance at 11:15 a.m. licens (LALD)-A and regist (RN/C)-D stated the management service R1 R1's diagnoses included R1's service plan daindicated R1 receive management. R1's signed prescrit 2024, included acet (heart health), calcidiclofenac sodium of failure), diltiazem (bidiclofenac sodium of failure)	on, interview, and record failed to ensure the N) conducted a face-to-face ement assessment to include for four of four residents (R1, providing medication ses. ed in a level two violation (at harm a resident's health or otential to have harmed a safety, but was not likely to a impairment, or death), and espread scope (when sive or represent a systemic cotted or has potential to affect of the residents). e: e: e: c: c: c: c: c: c: c:	01700			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLAC			
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01700	Continued From pa	ge 58	01700			
	chloride (suppleme	nstipation), potassium nt), quetiapine (anxiety), a), senokot (constipation) and				
	· · · · · · · · · · · · · · · · · · ·	t 12:15 p.m., the surveyor d personnel (ULP)-C ions to R1.				
	dated October 21, 2 Assessment section Management Section R1 required total as management and the medication review of prescriptions, over- supplements. Howe evidence the RN co- medications the res- to include indication effects, contraindical	rvice Evaluation assessment 2023, included a Medication and a Medication on. The assessment indicated sistance with medication at a RN had completed a of each of the resident's the-counter medications, and ever, R1's record lacked anducted a review of all sident was known to be taking as for medications, side ations, allergic or adverse ans to address these issues.				
	progressive demended deposits in nerve comment, thinking					
	·	ated April 30, 2024, indicated ince with medication				
	2024, included acet	ber orders dated April 30, aminophen (pain), a (tremors), vitamin B-12,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLI	ER STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLAG STER, MN 559			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
melatonin (sleep oxycodone (pain quetiapine (Park (overactive blade morphine sulfate) On May 21, 202 observed ULP-Compared to the second seco	ntia), finasteride (prostate),), naproxen sodium (pain),), miralax (constipation), inson's disease), trospium der), biotene (dry mouth), (pain), and lorazepam (anxiety). I, at 1:27 p.m., the surveyor administer medications to R2. Service Evaluation assessment 024, included a Medication tion and a Medication ction. The assessment indicated assistance with medication d that a RN had completed a w of each of the resident's er-the-counter medications, and wever, R2's record lacked conducted a review of all resident was known to be taking ions for medications, side dications, allergic or adverse etions to address these issues. Included diabetes, congestive art muscle doesn't pump blood as , and low back pain. Service Plan dated March 27, R4 received assistance with				
medication adm R4 lacked presc					
	I, at 7:12 a.m. the surveyor check R4's blood sugar and sulin.				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		31368	B. WING		05/2	24/2024
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLACE FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01700	Assessment section Management section R4 required total assessment and the medication review of prescriptions, oversupplements. How evidence the RN comedications the restorinclude indication effects, contraindicate reactions, and action R6's Service Plan of R6 received assistate administration. R6's prescriber orderincluded one for particulated one for particulated one for particulated one for particulated one for depression, cholesterol, one particulated one for overaction one for depression, cholesterol, one particulated one for overaction one for depression, cholesterol, one particulated one for overaction one for depression, cholesterol, one particulated one for overaction of the following	rvice Evaluation assessment 4, included a Medication n and a Medication on. The assessment indicated sistance with medication nat a RN had completed a of each of the resident's the-counter medications, and ever, R4's record lacked onducted a review of all sident was known to be taking as for medications, side ations, allergic or adverse ons to address these issues. uded dementia. lated March 9, 2024, indicated ance with medication ers dated May 7, 2024, in, five supplements, two for of for allergies, two skin cal pain gel, one for memory, one hormone cream, two for in patch, one for gastric reflux, ive bladder. at 7:34 a.m. the surveyor liminister medications to R6. rvice Evaluation assessment 23, included a Medication	01700			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLAC TER, MN 559			
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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
prescriptions, over supplements. How evidence the RN of medications the resto include indication effects, contraindications, and actions, and actions and actions are actions, and actions are actions, and actions are actions, and actions are actions. On May 23, 2024, (RN)-B stated R1, lacked a medication include the required in addition, RN-B stated R1, lacked a medication, RN-B stated R1, lacked a medication, assessment was a sessment w	of each of the resident's rethe-counter medications, and vever, R6's record lacked conducted a review of all esident was known to be taking ons for medications, side cations, allergic or adverse ons to address these issues. at 11:26 a.m. registered nurse R2, R4, and R6's records on management assessment to ed components as noted above. Stated the same medication used for all residents. velopment of the Individualized dement Plan and Individualized dated January 26, 2024, iding medication management ill review all medications the to be taking. This review must for medications, side effects, allergic or adverse reactions ress these issues.	01700			
01730 144G.71 Subd. 5 I SS=F management plan	ndividualized medication	01730			
management serv must prepare and written statement	ent receiving medication ices, the assisted living facility include in the service plan a of the medication management e provided to the resident. The				

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	
74101241	or correction.	IDEITH IO/THOMBEIT.	A. BUILDING:			
		31368	B. WING		05/2	4/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA			
			TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLETE DATE
01730	Continued From pa	ge 62	01730			
	facility must develor individualized mediceach resident bases assessment that medices management service (2) a description of on the resident's nediversion, and considirections; (3) documentation of relating to the admit (4) identification of monitoring medicates medication refills and (5) identification of tasks that may be of personnel; (6) procedures for some appropriate when a problem and management service (7) any resident-specifications that all as prescribed, and to prevent possible reactions. (b) The medication current and updates changes. (c) Medication recombed and medication managements or automedication managements and updates changes.	p and maintain a current cation management record for d on the resident's ust contain the following: cribing the medication ces that will be provided; storage of medications based eds and preferences, risk of istent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management delegated to unlicensed elicensed health professional ses with medication ces; and exific requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed rese, licensed health horized prescriber is providing				
	by:	on, interview, and record				

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review, the licensee failed to develop an

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLAGER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	LD BE	(X5) COMPLETE DATE
01730	the required content R2, R4, R6). This practice results violation that did not safety but had the president's health or cause serious injury was issued at a wide problems are pervate failure that has affect a large portion. The findings included During the entrance at 11:15 a.m. licens (LALD)-A and regist (RN/C)-D stated the management service R1 R1's diagnoses including ability to think, remethat affect daily life. R1's service plan daindicated R1 receives management. On May 21, 2024, a observed unlicense administer medication. R1's signed prescrit 2024, included acet (heart health), calcidiclofenac sodium of the content o	cation management plan with the for four of four residents (R1, and in a level two violation (and tharm a resident's health or extential to have harmed a safety, but was not likely to an impairment, or death) and espread scope (when sive or represent a systemic cited or has the potential to an or all of the residents). Example 1. Consultant to the consultant to the impairment of the loss of the ember, and reason to levels and activities). And October 26, 2023, and assistance with medication of the surveyor dispersonnel (ULP)-C	01730			

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	PLETED
		31368	B. WING		05/2	24/2024
	PROVIDER OR SUPPLIER VER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLAG FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01730	(reflux), miralax (conchloride (supplementamelteon (insomnitorsemide (diuretic)) R2 R2's diagnoses inclusive demendences in nerve concerns in nerve concerns in nerve concerns in the central nervous movement, often in R2's service plan da R2 received assistation management. On May 21, 2024, and observed ULP-C and R2's signed prescrit 2024, included acet carbidopa-levodapa done pezil (dementiamelatonin (sleep), roxycodone (pain), roxycodone (pain)	pine (anxiety), omeprazole nstipation), potassium nt), quetiapine (anxiety), a), senokot (constipation) and . uded Lewy Body Dementia (a tia that results from protein ells of brain. It affects a skills, mood, memory, and kinson's Disease (a disorder of system that affects cluding tremors). ated April 30, 2024, indicated ance with medication at 1:27 p.m., the surveyor diminister medications to R2. ber orders dated April 30, caminophen (pain), a (tremors), vitamin B-12, a), finasteride (prostate), naproxen sodium (pain), niralax (constipation), on's disease), trospium a), biotene (dry mouth), ain), and lorazepam (anxiety).	01730			
	medication adminis					

<u>Minneso</u>	<u>ita Department of He</u>	ealth				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		31368	B. WING		05/2	4/2024
					1 00.2	.,
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA TER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
01730	Continued From pa	ae 65	01730			
	R4 lacked prescribe	er oraers.				
	On May 21 2024 a	at 7:12 a.m. the surveyor				
		neck R4's blood sugar and				
	administer his insul	•				
	R6					
	R6's diagnoses incl	luded dementia.				
	R6's Service Plan o	dated March 9, 2024, indicated				
	R6 received assista	ance with medication				
	administration.					
	•	ers dated May 7, 2024,				
	•	in, five supplements, two for				
	•	o for allergies, two skin				
	· •	cal pain gel, one for memory,				
	· '	, one hormone cream, two for				
	cholesterol, one pa	in patch, one for gastric reflux,				
	and one for overact	tive bladder.				
		. 7 0 4				
	,	at 7:34 a.m. the surveyor				
	observed ULP-E ac	dminister medications to R6.				
	D1 D2 D4 and D6	S's records lacked evidence of				
		S's records lacked evidence of gement plan to include:				
		specific resident instructions				
		nistration of medications;				
		ersons responsible for				
	•	ion supplies and ensuring				
		re ordered on a timely basis;				
		,				
	- identification of M	edication management tasks				

Minnesota Department of Health

that may be delegated to unlicensed personnel;

(RN) when a problem arose with medication

documenting mediation administration,

- any resident-specific requirements relating to

verifications that all medications are administered

management services and;

- procedures for staff notifying a registered nurse

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	LETED
		31368	B. WING		05/2	4/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLAGER, MN 559			
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	use to prevent poss reactions. On May 23, 2024, at (RN)-B stated R1, Flacked a medication the required composite addition, RN-B state management plan of the licensee's Deveronded following the assessment, including resident's needs for RN develops an indomanagement plan for with the resident and representative. The c. identification instructions regarding staff will administer; d. identification monitoring medication monitoring medication fresponsible for the stasks, including tasks, including tasks staff; f. procedure for nurse there is a promanagement service g. any resident to the documentation administration, verificated as a staff; and the documentation and the documentation administration, verificated as a staff; and the documentation administration and the documentation administration and the documentation and the documentation administration and the documentation and	monitoring of medication to ible complications or adverse to 11:26 a.m. registered nurse R2, R4, and R6's records a management plan to include nents as noted above. In ed the same medication was used for all residents. Elopment of the Individualized ment Plan and Individualized dated January 26, 2024, completion of the nursing ing an assessment of the medication management, the ividualized medication or the resident in conjunction d/or the resident in conjunction d/or the resident's e plan will address: of any specific resident and medications our facility of the person responsible for on supplies and ensuring a timely basis; of the staff who are medication management as delegated to unlicensed them with any medication se; and specific requirements relating specific requirements relating	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
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NAME OF I	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
۸۱/۱۱/۸ DI	VER BEND	30 SILVER	LAKE PLA	CE NW			
AVIVA KI	VER BEND	ROCHEST	ER, MN 559	901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
01730	Continued From page 67		01730				
	No further information was provided.						
	TIME PERIOD FOR CORRECTION: Soldays	even (7)					
01760 SS=D			01760				
	Each medication administered by the a living facility staff must be documented resident's record. The documentation include the signature and title of the peradministered the medication. The document include the medication name, does and time administered, and method and administration. The staff must document reason why medication administration was completed as prescribed and document follow-up procedures that were provided the resident's needs when medication was administered as prescribed and in committed with the resident's medication manager. This MN Requirement is not met as expectively. Based on observation, interview, and resident is not met as expectively.	in the nust rson who mentation sage, date d route of nt the was not any d to meet was not pliance ment plan.					
	review, the licensee failed to ensure me were administered as prescribed for on residents (R2). In addition, the licensed ensure PRN (as needed) medication had documentation of effectiveness after administration for one of four residents	ne of four e failed to ad					
Minnesota D	This practice resulted in a level two violation that did not harm a resident's safety but had the potential to have har resident's health or safety) and was iss isolated scope (when one or a limited negartment of Health	health or med a ued at an					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/24/202	4
NAME OF PROVIDER OR SUPPLI	30 SILVEI	DRESS, CITY, ST R LAKE PLAC TER, MN 559	ENW		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMP	(5) PLETE ATE
of staff are involved only occasionally. The findings included in the progressive demonstrates of the central nerved movement, think behavior), and Pethe central nerved movement, often received assigned present the central nerved movement. On May 21, 2020 observed unlicer administer medial received assigned present the central nerved movement. On May 21, 2020 observed unlicer administer medial received assigned present the central nerved movement and the central nerved move	ected or one or a limited number yed, or the situation has occurred y). ude: NOT ADMINISTERED AS Included Lewy Body Dementia (a entia that results from protein e cells of brain. It affects ing skills, mood, memory, and arkinson's Disease (a disorder of us system that affects including tremors). In dated April 30, 2024, indicated stance with medication If, at 1:27 p.m., the surveyor ised personnel (ULP)-C cations to R2. Criber orders dated April 30, cetaminophen (pain), apa (tremors), vitamin B-12, intia), finasteride (prostate), naproxen sodium (pain), inson's disease), trospium der), biotene (dry mouth), (pain), and lorazepam (anxiety). Administration Record (MAR) May 2024, identified the				
	, the following medications tation of being administered:				

PRINTED: 07/01/2024

Minneso	ta Department of He	ealth			FURIVI APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		31368	B. WING		05/24/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
AVIVA RI	VER BEND		R LAKE PLA		
			TER, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
01760	Continued From pa	ge 69	01760		
	•	n (8 p.m. dose)			
	-	odopa (2 p.m. and 8 p.m.			
	dose)	, or or the second seco			
	-finasteride				
	-melatonin				
	-quetiapine -trospium				
	•	ne following medication lacked			
	documentation of b	•			
	-miralax				
	-vitamin B-12	the following medication			
		the following medication ion of being administered:			
		n (8 p.m. dose)			
	-carbidopa-levo	odopa (8 p.m. dose)			
	-finasteride				
	-melatonin				
	-quetiapine -trospium				
	ti oopiaiii				
		at 1:47 p.m., registered			
	,	RN/C)-D stated R2's record			
	lacked documentation as lie	ion of medication sted above. RN/C-D further			
		document any refusal of			
		reason why a medication was			
	not administered.				
	The licensee's Dec	umantation of Madication			
		umentation of Medication, rapy Management Services			
		ary 20, 2024, indicated staff			
	·	ach task immediately after that			

Minnesota Department of Health

administration.

task had been performed. It further stated

documentation would follow professional

R6 received assistance with medication

R6's Service Plan dated March 9, 2024, indicated

standards for documentation.

LACK OF PRN EFFECTIVENESS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLAG FER, MN 559			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760 Continued From page	ge 70	01760			
identified diclofenace apply 2 grams (gm) also apply 2 gm twick R6's May 1, 2024, the Summary identified following: - May 1, 2024, at 7: sodium gel administ documented. - May 7, 2024, at 7: sodium gel administ documented. - May 8, 2024, at 7: sodium gel administ documented. - May 17, 2024, at 7: sodium gel administ documented. - May 17, 2024, at 7 sodium gel administ documented. On May 23, 2024, at 7 sodium gel administ documented. On May 23, 2024, at 7 sodium gel administ documented. On May 23, 2024, at 7 sodium gel administ documented. The licenses was languaged and the resident 30 medication is given not. RN-B further so the effectiveness of the effectiveness of The licensee's Documented and There policy dated Februaged at the policy	ers dated May 7, 2024, sodium 1% gel (for pain), topically twice a day. May be daily PRN (back pain). Arough May 21, 2024, MAR the administration of the cered with no results of a.m. PRN diclofenactered with no results of a.m. PRN diclofenac				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE	

NAME OF I	PROVIDER OR SUPPLIER STREET	ADDRESS, CITY, S	STATE, ZIP CODE	
AVIVA RI	VER BEND	ER LAKE PLA		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of four residents (R4). The licensee further failed to ensure a prescription included the frequency of medication for one of five residents (R7). In addition, the licensee failed to obtain discontinued medication orders fone of five residents (R1) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one of a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LACK OF PRESCRIPTION ORDERS	or		

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Minneso	ota Department of He	ealth	_			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		31368	B. WING		05/:	24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLAG STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01820	Continued From pa	ige 72	01820			
		vice Plan dated March 27, received assistance with stration.				
	Summary dated Ma	ministration Record (MAR) by 2024, included Lantus c) 30 units subcutaneously once	3			
		at 7:12 a.m. the surveyor neck R4's blood sugar and lin.				
	R4 lacked prescribe	er orders.				
	(RN)-B stated R4 la	at 11:35 a.m. registered nurse acked prescriber orders. RN-E be signed prescriber orders and treatments managed by				
	R7's Service Plan	MEDICATION ORDER dated May 8, 2024, indicated ance with medication				
		ry dated May 2024, included ograms (1000 units) one table per day.	t			
		at 8:11 a.m. ULP-L was ster medications to R7,				

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frequency.

including Vitamin D3 25 mcg.

R7's prescriber orders dated May 8, 2024,

by mouth. R7's Vitamin D3 order lacked a

included Vitamin D3 25 micrograms (1,000 units)

On May 23, 2024, at 11:35 a.m. RN-B stated R7's

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	` '	E SURVEY PLETED
		31368	B. WING		05/	24/2024
	PROVIDER OR SUPPLIER	30 SILVEF	DRESS, CITY, S R LAKE PLAGE FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01820	RN-B stated each rinclude the medicate frequency. RN-B stated frequency. RN-B stated each rinclude the medicate frequency. RN-B state clarified with the problem of the pro	per order lacked a frequency. Inedication order should ion name, dosage, route, and lated the order needed to be ovider. IEDICATION uded dementia. IEDICATION uded dementia. IEDICATION uded dementia. IEDICATION uded dementia. In 12:15 p.m., the surveyor deminister medications to R1. In orders dated February 7, order for metoprolol succinate by mouth daily and ophthalmic solution; instill on the every evening. In 12:29 p.m., licensed every evening. In 12:29 p.m., licensed every even discontinued. In 12:29 p.m., licensed event prolol oprost had been discontinued. In It is record lacked a discontinue the medication. In 12:29 p.m. in licensed event plan and ladividualized event plan and ladividualized policy dated January 26, licensed nurse will request a lagend and over the counter every supplements that our	01820			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31368	B. WING		05/2	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND	30 SILVER	R LAKE PLA	CE NW		
AVIVAIN	VEIX DEIVE	ROCHEST	TER, MN 559	901		
(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 SHOUL) CROSS-REFERENCED TO THE APPROPOLICITION (PROPERTY)	D BE	(X5) COMPLETE DATE
01820	Continued From pa	ge 74	01820			
01880 SS=E	Medication and Tre January 26, 2024, resident's medication implemented in a time. Residents will be return from any medical providers. The RN/LPN will resident or resident or resident of any paperwork of any paperwork of additions to the resist treatment orders. All orders must be hours of receipt of the total orders must be hours of receipt of the total orders. The RN/LPN we signature on any very possible. All action prescriber's signature or any very possible. All action prescriber's medical resident's medical resi	atment Orders policy dated noted all changes in the on or treatment orders will be mely and effective manner. e asked to see the nurse upon dical visit. I request an update from the 's family and will make a copy iven to the resident by the will be reviewed for changes or ident's medication or the implemented within 24 he order. It obtain the prescriber's in the order as soon as as taken to obtain the ire will be documented in the record. CORRECTION: Seven (7)	01880			
	prescription medical substantially constructed according to the management only authorized by:	acility must store all ations in securely locked and ucted compartments anufacturer's directions and sed personnel to have access. ent is not met as evidenced on, interview, and record				

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review, the licensee failed to ensure all

medications were securely locked in substantially

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	31368	B. WING		05/	24/2024
NAME OF PROVIDER OR SUF	30 SILVE	DDRESS, CITY, STER LAKE PLACESTER, MN 559	ENW		
PREFIX (EACH DEF	RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
authorized per the potential is memory care. This practice violation that safety but had resident's head cause serious was issued a limited number than a limited situation has found to be posserved unling preparing meating the medications of	compartments and permitted only ersonnel to have access. This had to affect all residents residing in the resulted in a level two violation (a did not harm a resident's health or did the potential to have harmed a faith or safety, but was not likely to sinjury, impairment, or death) and the apattern scope (when more than a fer of residents are affected, more number of staff are involved, or the occurred repeatedly; but is not ervasive). Include: O24, at 8:10 a.m., the surveyor censed personnel (ULP)-C dications for a resident. ULP-C left in cart unlocked while she brought to the resident's room. O24, at 8:35 a.m., the surveyor unlocked medication cart with no for approximately five minutes. returned to the medication cart, the ired if the medication cart should be unattended, and ULP-C stated she did that must have forgotten. O24, at 1:20 p.m., the surveyor unlocked medication cart with no Six residents were in the common that the unlocked medication cart.				
nurse/consult	024, at 1:41 p.m., registered ant (RN/C)-D stated the medication be locked when unattended.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	LETED
31368 B. WING 05/2	4/2024
	1/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
30 SILVER LAKE PLACE NW	
ROCHESTER, MN 55901	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE
DEFICIENCY)	
01880 Continued From page 76 01880	
Continued From page 70	
The licensee's Storage of Medications policy	
dated February 20, 2024, indicated medications	
would be handled and stored per acceptable	
standards.	
No further information provided.	
No futile illioitiation provided.	
TIME PERIOD FOR CORRECTION: Seven (7)	
days	
01910 144G.71 Subd. 22 Disposition of medications 01910 SS=F	
(a) Any current medications being managed by	
the assisted living facility must be provided to the	
resident when the resident's service plan ends or	
medication management services are no longer	
part of the service plan. Medications for a	
resident who is deceased or that have been	
discontinued or have expired may be provided for	
disposal.	
(b) The facility shall dispose of any medications	
remaining with the facility that are discontinued or	
expired or upon the termination of the service	
L PONTERPE OF THE COCIDENTE ACOID REPORTING TO CISTO	
contract or the resident's death according to state	
and federal regulations for disposition of	

Minnesota Department of Health

by:

medication including the medication's name,

strength, prescription number as applicable,

individuals involved in the disposition.

quantity, to whom the medications were given,

date of disposition, and names of staff and other

This MN Requirement is not met as evidenced

Based on interview and record review, the

licensee failed to document in the resident's

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOSILVER LAKE PLACE NW ROCHESTER, MIN 55901		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	COMP	LETED
AVIVA RIVER BEND 30 SILVER LAKE PLACE NW ROCHESTER, MN 55901 (CA) ID PRETIX (EACH DEPRICENCY MUST BE PRECEDED BY FULL TAG) TAG O1910 Continued From page 77 record the disposition of the medication including the prescription numbers as applicable, and to whom the medications were given for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on December 1, 2017, and discharged on April 27, 2024, to another facility. R3's Record of the Medications Upon Discharge from Assisted Living Facility from dated April 27, 2024, had columns that identified the medication, dose, quantity, a signature line for the facility nursing releasing the medications and a second signature line for the responsible party. On May 22, 2024, at 1.45 p.m., registered nurse/consultant (RN/C)-D confirmed R3 received medication management services and stated the facility's Discharge/Leave of Absence Medication form did not include a a rear for the prescription number as required. RN/C-D further			31368	B. WING		05/2	4/2024
PREFIX TAG REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG O1910 Continued From page 77 record the disposition of the medication including the prescription numbers as applicable, and to whom the medications were given for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but had the potential to have harmed a resident's health or safety but had sudespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on December 1, 2017, and discharged on April 27, 2024, to another facility. R3's Record of the Medications Upon Discharge from Assisted Living Facility form dated April 27, 2024, had columns that identified the medication, dose, quantity, a signature line for the facility nursing releasing the medications and a second signature line for the responsible party. The document did not include a column for the prescription number. The document was not signed by the resident or responsible party. On May 22, 2024, at 1:45 p.m., registered nurse/consultant (RNC)-D confirmed R3 received medication management services and stated the facility's Discharge/Leave of Absence Medication form did not include an area for the prescription number as required. RNIC-D further			30 SILVEF	R LAKE PLA	CE NW		
record the disposition of the medication including the prescription numbers as applicable, and to whom the medications were given for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on December 1, 2017, and discharged on April 27, 2024, to another facility. R3's Record of the Medications Upon Discharge from Assisted Living Facility form dated April 27, 2024, had columns that identified the medication, dose, quantity, a signature line for the facility nursing releasing the medications and a second signature line for the responsible party. The document did not include a column for the prescription number. The document was not signed by the resident or responsible party. On May 22, 2024, at 1:45 p.m., registered nurse/consultant (RNIC)-D confirmed R3 received medication number as required. RNI/C-D further	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
stated R3's medications were given to R3's family member which should have been documented	01910	record the disposition the prescription number side and safety but had the president's health or cause serious injury was issued at a wide problems are pervasifial failure that has affect a large portion or all the findings included R3 was admitted to 2017, and discharge another facility. R3's Record of the from Assisted Living 2024, had columns dose, quantity, a signature line for the document did not in prescription number signed by the resided On May 22, 2024, and another facility's I Medication form did prescription number stated R3's medication stated R3's medication stated R3's medication form did prescription number stated R3'	on of the medication including obers as applicable, and to ons were given for one of one it (R3). In a level two violation (and tharm a resident's health or obtential to have harmed a safety, but was not likely to an expread scope (when sive or represent a systemic content of the residents). In the licensee on December 1, and the december 1, and the december 27, 2024, to the licensee on December 1, and the december 3, and the december 4, an	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

30 SILVER LAKE PLACE NW

AVIVA RIVER BEND ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01910	not. The licensee's Disposition or Disposal of Medication policy dated February 20, 2024, indicated staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of the	01910			
	medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days				
01940 SS=E		01940			

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` '	ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
31368	}	B. WING		05/2	4/2024
AVIVA RIVER BEND		DRESS, CITY, S R LAKE PLAG FER, MN 559			
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
(5) any resident-specific require documentation of treatment and received, verification that all tree therapy was administered as propossible complications or advestreatment or therapy management be current and updated when the changes. This MN Requirement is not me by: Based on observation, interview review, the licensee failed to desimplement a treatment or theraplan to include all required content three residents (R4, R5, R1). This practice resulted in a level violation that did not harm a resisted but had the potential to here is safety but had the potential to here. This MN Requirement is not me had possible to here is not me had possible to here. The findings include is not me had possible to here is not me had possible to here. The findings include is not me had possible to here. The findings include is not me had possible to here. The findings include is not me had possible to here.	d therapy eatment and rescribed, and apy to prevent rse reactions. The lent record must here are any net as evidenced by, and record evelop and apy management tent for three of two violation (a sident's health or nave harmed a was not likely to nt, or death) and (when more than a saffected, more are involved, or the dly; but is not end of the diving director for consultant rovided treatment residents.	01940			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LETED
		31368	B. WING		05/24/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
۸\/I\/۸ D	IVER BEND	30 SILVEF	R LAKE PLA	CE NW		
AVIVAR	IVER BEIND	ROCHEST	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 80	01940			
	2024, indicated R4 assistance with ass R4's service plan di (thrombo-embolic d	vice Plan dated March 27, received services including sistance with boot and brace. id not identify TED leterrent) sock (compression ease circulation to prevent				
	R4 lacked prescriber orders.					
	On May 21, 2024 at 7:12 a.m. R4 was observed wearing a TED stocking and an AFO (ankle-foot orthosis) brace (a specialized device designed to support and stabilize the foot and ankle region) to his left leg. In addition, he was wearing a Darco (specialized shoe to off-load pressure from the foot) shoe/boot on his right foot. Unlicensed personnel (ULP)-E stated R1 required assistance to apply the TED stocking, AFO brace, and Darco shoe/boot daily.					
	R4's Monthly Task Log dated May 1, 2024, through May 21, 2024, lacked documentation of TED stocking, AFO, and Darco shoe/boot assistance.					
	plan to include the the use of compres - a statement of the provided; - documentation of relating to the treating administration; - identification of treating to the delegated to - procedures for not the treating to the tr	type of services that will be specific resident instructions				

Minnesota Department of Health

services; and

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLAΩ ΓER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01940	documentation of triverification that all tradministered as present treatment or therapy complications or ad R5 R5's diagnoses includes that affect R5's Service Plan of R5 received assistate airway pressure (Cluplan did not identify R5 lacked prescribes machine and TED so On May 20, 2024, a wearing bilateral TE them on in the mornight. In addition, FCPAP placement at R5's Monthly Task I through May 21, 20 and TED stockings evening. R5's records lacked plan to include the fitte use of compression a statement of the provided;	ific requirements relating to eatment and therapy received, reatment and therapy was escribed and monitoring of y to prevent possible verse reactions. uded cerebellar ataxia is balance and coordination). lated May 7, 2024, indicated ince with continuous positive PAP) machine. R5's service TED socks. er orders for the CPAP socks. at 3:22 p.m. R5 was observed ED socks. R5 stated staff puthing and remove them at est stated staff assist him with a night. Log dated May 1, 2024, 24, included CPAP at night on in the morning, off in the est at treatment management following required content for sion stockings: type of services that will be specific resident instructions	01940	DEPICIENCY)		
	administration;	eatment or therapy tasks that				

Minneso	ta Department of He	ealth			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		31368	B. WING		05/24/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
AVIVA R	VER BEND		ER LAKE PLA STER, MN 559		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
01940	- procedures for no a problem arose wi services; and - any resident-spectocumentation of transfer verification that all tradministered as protreatment or therap complications or accomplications or accomplicated R1 R1's diagnoses incomplicated R1 receiving grooming/personal toileting, mobility/ar housekeeping, laur	tifying a registered nurse whe th treatments or therapy ific requirements relating to reatment and therapy received reatment and therapy was escribed and monitoring of by to prevent possible liverse reactions. Indeed dementia. ated October 26, 2023,			

R1's physician orders dated February 23, 2024, included an order for weekly weights; notify provider of 3-5 pound weight gain or loss.

R1's Medication Administration Record (MAR) Summary dated May 2024, indicated R1 received assistance with weekly weights.

R1's record lacked a treatment management plan to include the following required content for weekly weights:

- a statement of the type of services that will be provided;
- documentation of specific resident instructions relating to the treatments or therapy administration;
- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
- procedures for notifying a registered nurse when

Minnesota Department of Health

weekly weights.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	24/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
A) (I) (A D)	VED DEND	30 SILVEF	R LAKE PLA	CENW		
AVIVA RI	VER BEND	ROCHEST	ΓER, MN 559	901		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	,	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
01940	Continued From pa	ge 83	01940			
	a problem arose wing services; and	th treatments or therapy				
		fic requirements relating to				
		reatment and therapy received,				
		reatment and therapy was escribed and monitoring of				
	·	y to prevent possible				
	complications or ad	verse reactions.				
	On May 23, 2024, a	at 11:43 a.m. RN-B stated R4,				
	R5, and R1's record	lacked a treatment				
		o include all the required				
	content as noted at	oove.				
	The licensee's Deve	elopment of the Individualized				
		py Management Plan policy				
		2024, indicated a RN would alized treatment				
	·	t in accordance with physician				
	•	nction with the resident and/or				
	·	sentative. The plan would				
	address:	of the treatment or therapy				
		ces to be provided by our				
	facility;					
		of any specific resident				
	our facility staff will	ng the treatments or therapy administer:				
		of the staff who are				
	•	treatment or therapy				
	_	, including tasks delegated to				
	unlicensed staff;	or staff to notify the licensed				
	-	blem with any treatments or				
	therapy manageme	<u> </u>				
		-specific requirements relating				
		f treatments or therapy				
	·	fication that all treatments are escribed and monitoring of				
	-	pies to prevent possible				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVIVA RIVER BEND ROCHESTER, MN 55901						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
01940	Continued From page 84	01940				
	complications or adverse reactions.					
	No further information was provided.					
	TIME PERIOD FOR CORRECTION: Seven (7) days					
01960 SS=D		01960				
	Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee lacked documentation of treatments for two of three residents (R1, R4).					
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).					
	The findings include:					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLA FER, MN 559			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01960 Continued From pa	ige 85	01960			
indicated R1 received grooming/personal toileting, mobility/and housekeeping, laur management. R1's weekly weights. R1's physician order for provider of 3-5 pour R1's Medication Ad Summary dated Massistance with we -On May 4, 2024, Fas 180 pounds (lbs -On May 11, 2024, completion of R1's -On May 18, 2024, as 174 lbs. On May 22, 2024, as 174 lbs. On May 22, 2024, as 174 lbs.	ated October 26, 2023, red assistance with hygiene, dressing, bathing, inbulation, transfers, adry, and medication service plan did not include ers dated February 23, 2024, or weekly weights; notify and weight gain or loss. Iministration Record (MAR) ay 2024, indicated R1 received ekly weights. R1's weight was documented				
	luded diabetes, congestive w back pain.				

Minnesota Department of Health

R4's unsigned, Service Plan dated March 27,

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	COMP	LETED
		31368	B. WING		05/2	4/2024
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLAGER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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	(X5) COMPLETE DATE
01960	Continued From pa		01960			
	assistance with ass bathing, dressing, growthing, medication mobility/ambulation and laundry. R4's stated to prevent swelling) On May 21, 2024, a observed unlicense R4's blood sugar arrows observed wear AFO (ankle-foot ortoward ankle region) to and ankle region) to was wearing a Darropressure from the foot. ULP-E stated	received services including istance with a boot and brace, rooming/personal hygiene, administration, transferring, housekeeping, service plan did not identify olic deterrent) sock used to increase circulation or blood sugar checks. It 7:12 a.m. the surveyor d personnel (ULP)-E check administer his insulin. R4 ing a TED stocking and an hosis) brace (a specialized support and stabilize the foot o his left leg. In addition, he co (specialized shoe to off-load bot) shoe/boot on his right R1 required assistance to king, AFO brace, and Darco				
	R4 lacked prescribe					
	through May 21, 20	Log dated May 1, 2024, 24, lacked documentation of brace, or Darco shoe/boot				
	ULP should be docuservices and treatments record lacked	t 11:43 a.m., RN-B stated umenting the completion of all ents provided. RN-B stated documentation of the TED e, and Darco shoe/boot				
	Treatment or Thera	elopment of the Individualized py Management Plan policy 2024, indicated treatment or				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	31368	B. WING	05/24/2024

NAME OF F	PROVIDER OR SUPPLIER STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
AVIVA RI	VER BEND	R LAKE PLACESTER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 87 therapy services would be documented and maintained as part of the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment of therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for two of three residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:			
Minnesota D	epartment of Health	r I		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	24/2024
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLACE FER, MN 559			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01970 Continued From pa	ge 88	01970			
at 11:15 a.m. licens (LALD)-A and regis (RN/C)-D stated the	e conference on May 20, 2024, ed assisted living director tered nurse/consultant e licensee provided treatment ces to their residents.				
R4 R4's diagnoses incl heart failure, and lo	uded diabetes, congestive w back pain.				
2024, indicated R4 assistance with ass R4's service plan di (thrombo-embolic d	eterrent) sock (compression ase circulation to prevent				
observed unlicense R4's blood sugar ar was observed wear AFO (ankle-foot ort device designed to and ankle region) to was wearing a Dard pressure from the foot. ULP-E stated	at 7:12 a.m. the surveyor d personnel (ULP)-E check administer his insulin. R4 sing a TED stocking and an hosis) brace (a specialized support and stabilize the foot o his left leg. In addition, he so (specialized shoe to off-load oot) shoe/boot on his right R1 required assistance to king, AFO brace, and Darco				
dated March 7, 202 with TED stockings testing and monitor identify R4 required Darco shoe/boot on	rvice Evaluation assessment 4, indicated staff assisted R4 and required blood sugar ing. The assessment did not an AFO to his left leg or his right foot. ministration record (MAR)				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	IVER BEND		R LAKE PLAGER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01970	Continued From pa	ge 89	01970			
	2024, included docu checks four times a dated May 1, 2024,	y 1, 2024, through May 21, umentation of blood sugar day. R4's Monthly Task Log through May 21, 2024, lacked ED stocking, AFO brace, or sistance.				
	R4 lacked prescribe	er orders.				
		uded cerebellar ataxia s balance and coordination).				
	R5 received assista	lated May 7, 2024, indicated ince with continuous positive PAP) machine. R5's service TED socks.				
	wearing bilateral TE them on in the morr	t 3:22 p.m. R5 was observed ED socks. R5 stated staff put ning and remove them at 85 stated staff assisted him ent at night.				
	dated May 7, 2024,	rvice Evaluation assessment did not identify R5 required placement at night.				
	through May 21, 20	Log dated May 1, 2024, 24, included CPAP every night in the morning off in the				
	R5 lacked prescribe machine and TED s	er orders for the CPAP socks.				
	R4 and R5's record the treatments com	t 11:43 a.m. RN-B stated both lacked prescriber orders for pleted by staff each day as N-B further stated there				

Minneso	ta Department of He	ealth				
AND PLAN OF CORRECTION TO IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31368	B. WING		05/2	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RI	VER BEND		R LAKE PLA TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01970	The licensee's Dev Treatment or Thera dated January 26, 2 be responsible for rorders for treatment be responsible for orders for treatment be responsible for orders on the resist treatment or therapatherapies are physicare not limited to: - glucometer use at - CPAP - TED socks No further information	elopment of the Individualized apy Management Plan policy 2024, indicated the RN would requesting/receiving physician ats or therapies. The RN would communicating with the seneeded basis for changes or ident's response to the by provided. Treatment or cian ordered and include but and monitoring	01970			
02040 SS=F		on 1 Fire protection and ent	02040			

Minnesota Department of Health

by August 1, 2029.

An assisted living facility with dementia care that

has a secured dementia care unit must meet the

(1) a hazard vulnerability assessment or safety

assessment must be assessed and mitigated to

(2) the facility shall be protected throughout by an

approved supervised automatic sprinkler system

This MN Requirement is not met as evidenced

requirements of section 144G.45 and the

risk must be performed on and around the

property. The hazards indicated on the

protect the residents from harm; and

following additional requirements:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLAC TER, MN 559			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
of the physical environ property with mitigation. This deficient practice dementia care resident. This practice resulted violation that did not have a safety but had the poteresident's health or sawidespread scope (whor represent a systemior has the potential to of the residents). Findings include: On May 24, 2024, mai and licensed assisted provided documents for vulnerability assessment emergency preparednessed technological, and hum additionally, an annual assessment had been safety risks to resident safety risks to resident safety risks was not in the physical environment or hazards on and aromitigation factors for a a secured dementia carcompleted. During an interview, or	w and interview, the ide a safety risk I vulnerability assessment ament on and around the infactors for the facility. had the ability to affect all its and staff. in a level two violation (a arm a resident's health or ential to have harmed a fety) and was issued at a nen problems are pervasive ic failure that has affected affect a large portion or all intenance director (LALD)-A or review. A hazard and ent completed as part of the ess plan for natural, man hazards was provided. I hazard vulnerability is completed which identified its, but mitigation of these cluded. An assessment of ent identifying safety risks und the property with an assisted living facility with are unit had not been in May 24, 2024, at 12:40. A verified the completed				

Minneso	ta Department of He	ealth				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		31368	B. WING		05/24/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
AVIVA R	VER BEND		R LAKE PLA STER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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	
02040	Continued From pa	ge 92	02040			
02140 SS=F	(21) days 144G.83 Subd. 3 S Persons providing of must have experient of individuals with of (1) two years of work Alzheimer's disease health care, geront and (2) completion of requirements in this passing a skills contract the contract of the contract	upervising staff training or overseeing staff training nee and knowledge in the care lementia, including: rk experience related to e or other dementias, or in clogy, or another related field; of training equivalent to the section and successfully inpetency or knowledge test numissioner. ent is not met as evidenced and record review, the esignate a qualified person to	02140			
	oversee staff trainir	ng in the care of individuals shad the potential to affect all				

The findings include:

the residents).

residents, staff, and visitors.

During the entrance conference on May 20, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-A stated the memory care

This practice resulted in a level two violation (a

violation that did not harm a resident's health or

resident's health or safety) and was issued at a

widespread scope (when problems are pervasive

or represent a systemic failure that has affected

or has the potential to affect a large portion or all

safety but had the potential to have harmed a

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMP	SURVEY	
		31368	B. WING		05/2	24/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	,	
AVIVA RI	IVER BEND		R LAKE PLA TER, MN 559			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02140	On May 23, 2024, a had not completed knowledge test requassisted living facilit further stated he was required training the The licensee's Assis Dementia Training indicated the superstaff training would to the requirements successfully pass a knowledge test requirements.	oversaw the staff training in the with dementia. at 8:31 a.m., MCM-I stated he any approved competency or uired for supervising staff in an ty with dementia care. MCM-I as scheduled to complete the e following week. sted Living with Memory Care policy dated January 1, 2024, visor providing or overseeing complete training equivalent in this section and a skills competency or uired by the commissioner.				
02170 SS=F	(b) Each resident maccording to the lice addition, the evaluation following: (1) past and current (2) current abilities (3) emotional and s (4) physical abilities (5) adaptations necessaricipate; and (6) identification of a interventions.	and skills; ocial needs and patterns;	02170			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		31368	B. WING		05/2	24/2024
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
AVIVAR	IVER BEIND	ROCHES	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02170	activity evaluation. resident's activity procession of data non-structured activities included on the resident evaluation included on the resident evaluation or resident evaluation in the total limited to: (1) occupation or characteristic (2) scheduled and procession or characteristic (3) spontaneous activate may help defuse (4) one-to-one activate relationships betwee telling a life story, refused (5) spiritual, creativate (6) sensory stimulation (7) physical activities resident's ability to (8) outdoor activities (8) outdoor activities addressed all six procession of the procession of the total control of th	resident based on their The plan must reflect the references and needs. aily structured and vities must be provided and ident's activity service or care . Daily activity options based ion may include but are not nore related tasks; planned events such as stings; tivities for enjoyment or those se a behavior; vities that encourage positive en residents and staff such as eminiscing, or playing music; e, and intellectual activities; tion activities; es that enhance or maintain a ambulate or move; and s. ent is not met as evidenced on, interview, and record e failed to conduct an en activity evaluation that rovisions and failed to develop ctivity plan based on the of two residents (R1 and R2) ces under the assisted living license and resided in the	02170			

Minnesota Department of Health

AND PLAN OF CORRECTION INTERCATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
		31368	B. WING	05/24/2024
	NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STATE, ZIP CODE	

NAME OF F	PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
AVIVA RI	VER BEND	R LAKE PLA TER, MN 559		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 95	02170		
	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 had an assisted living with dementia care license.			
	R1 R1 was admitted on February 9, 2023, with diagnoses that included dementia.			
	On May 21, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.			
	R1's service plan dated October 26, 2023, indicated R1 received assistance with grooming/personal hygiene, dressing, bathing, toileting, mobility/ambulation, transfers, housekeeping, laundry, and medication management.			
	R1's Lifetime Memoir dated April 14, 2024, included past and current interests. R1's record lacked the following: -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions			
	R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment.			
Minnosoto D	R2 epartment of Health			

Minnesota Department of Health

STATE FORM UHZF11 UHZF11 If continuation sheet 96 of 104

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	COMPI	LETED
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVEF	DRESS, CITY, S R LAKE PLAGE FER, MN 559			
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progressive dementing deposits in nerve cemovement, thinking behavior), and Parkithe central nervous is movement, often incomovement, often incomovement deposition of activities and indicated past and collacked the following: -current abilities and emotional and social physical abilities and emotional and social physical abilities and individual abilities and individual activities and individualized activities activity assessment. On May 21, 2024, at manager (MCM)-1 st the activity assessment memory care. MCM-aware of the six province.	April 30, 2024, with ded Lewy Body Dementia (a ia that results from protein Ils of brain. It affects skills, mood, memory, and inson's Disease (a disorder of system that affects cluding tremors). It 1:27 p.m., the surveyor minister medications to R2. Ited April 30, 2024, indicated nce with dressing, bathing, abulation, escorts, dry, and medication ir dated May 7, 2024, surrent interests. R2's record is skills all needs and patterns d limitations cary for the resident to vities for behavioral				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	31368	B. WING		05/2	4/2024
NAME OF PROVIDER OR SUPPLIER AVIVA RIVER BEND	30 SILVE	R LAKE PLA			
	ROCHES	TER, MN 559	901		
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02170 Continued From p	age 97	02170			
Programs and Hor ALDC policy dated 1. Each resident worth the evaluation must a. Past and curred b. Current abilities c. Emotional and d. Physical abilities. Adaptations in participate, and f. Identification of interventions 4. An individualize for those receiving on their activity evaluate the resident's activity. No further informated TIME PERIOD FOR (21) days 144G.91 Subd. 4 diservices (a) Residents have living services that resident's needs a service plan subject standards. This MN Requirements by: Based on observative were provided to the services were provided	ent interests es and skills I social needs and patterns es and limitations ecessary for the resident to of activities for behavioral diactivity plan will be developed assisted living services based aluation. The plan will reflect vity preferences and needs. The CORRECTION: Twenty-One				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		31368	B. WING		05/2	4/2024
	PROVIDER OR SUPPLIER	30 SILVER	DRESS, CITY, S R LAKE PLACE ER, MN 559			
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02310	rails. In addition, the care and services we acceptable health of standards for two of assistive devices (control of the control of the contr	s (R2) with hospital-style side e licensee failed to ensure the vere provided according to are, medical, or nursing f two residents (R5, R4) with onsumer purchased side rail). immediate order on May 21, and in a level three violation (and a resident's health or safety, in sinjury, impairment, or death, as the potential to lead to imment, or death), and was scope (when more than a residents are affected, more over of staff are involved, or the red repeatedly; but is not eat a feet of brain. It affects is skills, mood, memory, and can son's Disease (disorder of system that affects cluding tremors).	02310			

Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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PRÉFIX TAG REGULATORY OR LOC IDENTIFYING INFORMATION) O2310 Continued From page 99 observed to have a hospital bed with a right upper side rail in the up position. R2's record lacked documentation of a side rail assessment, documentation of a risks versus benefits of side rail use education, documentation of the measurements of R2's side rail, and documentation (FDA) recommendations. On May 21, 2024, at 9.06 a.m., registered nurse consultant (RNI/C)-D stated R2's record lacked the required side rail assessment, risk versus benefits discussion, documentation of the measurements of the side rail, and documentation that the side rail met the FDA recommendations. CONSUMER PURCHASED SIDE RAILS R5 On May 20, 2024, at 3:22 p.m., the surveyor observed upper bilateral side rails on R5's twin sized bed. The side rails to help get in and out of bed. R5 further indicated his son had purchased the side rails. R5's diagnoses included cerebellar ataxia (disorder that affects balance and coordination). R5's service plan dated May 7, 2024, indicated R5 received assistance with continuous positive airway pressure (CPAP) machine (helps an individual to breather continuously while they sleep), dressing, grooming/personal hygiene, mobility/ambulation, toileting, transferring, housekeeping, and laundry. R5's Health and Service Evaluation assessment		30 SILVEF	R LAKE PLAG	CENW		
observed to have a hospital bed with a right upper side rail in the up position. R2's record lacked documentation of a side rail assessment, documentation of a risks versus benefits of side rail use education, documentation of the measurements of R2's side rail, and documentation R2's side rail, and documentation R2's side rail, and documentation (FDA) recommendations. On May 21, 2024, at 9:06 a.m., registered nurse consultant (RN/C)-D stated R2's record lacked the required side rail assessment, risk versus benefits discussion, documentation of the measurements of the side rail, and documentation that the side rail met the FDA recommendations. CONSUMER PURCHASED SIDE RAILS R5 On May 20, 2024, at 3:22 p.m., the surveyor observed upper bilateral side rails on R5's twin sized bed. The side rails were secure and R5 stated he used the side rails to help get in and out of bed. R5 further indicated his son had purchased the side rails. R5's diagnoses included cerebellar ataxia (disorder that affects balance and coordination). R5's service plan dated May 7, 2024, indicated R5 received assistance with continuous positive airway pressure (CPAP) machine (helps an individual to breathe continuously while they sleep), dressing, grooming/personal hygiene, mobility/ambulation, tolleting, transferring, housekeeping, and laundry. R5's Health and Service Evaluation assessment	PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE
dated May 7, 2024, noted:	observed to have side rail in the up R2's record lacked assessment, door benefits of side rate of the measurem documentation R Drug Administration on May 21, 2024 consultant (RN/C) the required side benefits discussion measurements of documentation the recommendation CONSUMER PUR5 On May 20, 2024 observed upper to sized bed. The sit stated he used the of bed. R5 further purchased the side R5's diagnoses in (disorder that affect R5's service plan R5 received assist airway pressure (individual to breat sleep), dressing, mobility/ambulation housekeeping, and R5's Health and States and States are side of the side o	a hospital bed with a right upper position. d documentation of a side rail umentation of a risks versus ill use education, documentation ents of R2's side rail, and 2's side rail met the Food and on (FDA) recommendations. , at 9:06 a.m., registered nurse object to be a side rail assessment, risk versus on, documentation of the fithe side rail, and at the side rail met the FDA side. RCHASED SIDE RAILS , at 3:22 p.m., the surveyor illateral side rails on R5's twin de rails were secure and R5 e side rails to help get in and out redicated his son had le rails. Included cerebellar ataxia ects balance and coordination). dated May 7, 2024, indicated stance with continuous positive CPAP) machine (helps and the continuously while they grooming/personal hygiene, on, toileting, transferring, and laundry. Service Evaluation assessment				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	31368	B. WING	05/24/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					

	·			•	727/2027	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
A) (I) (A D)	V.ED DENID	30 SILVER	R LAKE PLA	CE NW		
AVIVA RI	IVER BEND	ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
02310	Continued From page 100		02310			
	 bilateral side rails on hospital bed; used side rails for bed mobility or other functional assistance only; side rails or other supportive device had checked and are sturdy and in good contrisks and benefits for use of side rails of supportive device had been discussed where sident and/or resident's representative. R5's record lacked manufacturer's guide installation and use of the consumer purside rails and lacked evidence the license referred to the Consumer Product Safety Commission (CPSC) for side rail recall information. 	as been adition; or other with e. elines for rchased see				
	R4 On May 21, 2024, at 7:12 a.m., the survent observed a square shaped consumer puside rail on the right upper side of R4's feet that tucked under the mattress. R4's diagnoses included diabetes, congenteer failure, and low back pain.	urchased full sized				
	R4's unsigned, service plan dated March 2024, indicated R4 received services ind assistance with bathing, dressing, grooming/personal hygiene, medication administration, mobility/ambulation, transhousekeeping, and laundry.	cluding				
	R4's Health and Service Evaluation assed dated March 7, 2024, noted: - resident uses side rail or other support device; - used side rails for bed mobility or other functional assistance only; - side rails or other supportive device has checked and are sturdy and in good conepartment of Health	ive r as been				

STATE FORM UHZF11 UHZF11 If continuation sheet 101 of 104

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		31368	B. WING		05/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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0/ 0 15	CLIMANA DV CTA		<u>, </u>		<u></u>	()/(5)
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02310	Continued From pa	ge 101	02310			
	supportive device h	for use of side rails or other ad been discussed with dent's representative.				
	installation and use side rails and lacke	manufacturer's guidelines for of the consumer purchased devidence the licensee C for side rail recall				
	both R5 and R4 had rails on their respect as identified in R5's she had recommen recall and include the for the consumer put	at 9:35 a.m. RN/C-D stated consumer purchased side ctive beds (not a hospital bed assessment). RN/C-D stated ded the licensee check for ne manufacturer's instructions urchased side rails but was a R5 and R4's record.				
	policy, undated, ind 1. At the time of more in condition, discove expresses a desire complete a device-e electronic health red determine the approx 2. The licensed nurs risks and benefits of and/or family. 3. If the device is us reviewed for safety RN determines that device for the client and alternatives for self to the client, the the client's family. The recommended option	essing the Safety of Side Rails icated the following: eve in, hospital return, change ery of a rail, or if the resident to use a device the nurse with equipment assessment in the cord (EHR) the resident to opriateness of the device. See or designee will review the f device use with the resident sed on a bed, it will be using FDA guidelines. If the the side rails are not a safe the RN will provide options reducing fall or positioning eclient's representative and/or the RN will document these ons and the response from the				
	-	, and client's representative to				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
	31368	B. WING	_	05/2	4/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER BEND		R LAKE PLA			
	ROCHES	ΓER, MN 559	901		
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02310 Continued From pa	ge 102	02310			
facility owned bed in manufacturer's instead of the second to include: record to include: record to with research to the second	her device is placed on a will be installed according to ructions. vill be entered in the residents' esults of the assessment, ident/family regarding risks ecision made/outcome of				
2010, included the bed rails are used, assessment of the status, closely mon FDA also identified; with memory, sleep uncontrolled body rebed and walk unsate be carefully assess them from harm, suthe patient's health determine how bes. The Minnesota Depwebsite, Assisted Lasked Questions (Findividual is an apprail, the licensee mecognitive and physithe bed rail to deter the bed rail and whrisk for entrapment assessment of the needs, pain, unconability to transfer in assistance. The lice whether the bed rail improper restraint."	out a resident's bed rails				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	31368	B. WING	05/24/2024			
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	20 011 1/51					

NAME OF	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
AVIVA RIVER BEND		30 SILVER LAKE PLACE NW				
	VERBEND	ROCHEST	ER, MN 559	901		
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02310		large ped) of sment; ized to for st include not ed frame	02310			

Minnesota Department of Health

STATE FORM UHZF11 UHZF11 If continuation sheet 104 of 104



Minnesota Department of Health **Environmental Health - FPLS**

Rochester

Type: Full

05/21/24 Date: Time: 10:05:57 1038241057 Report:

Food and Beverage Establishment Inspection Report

Page 1

Location:

River Bend Assisted Living & M 30 Silver Lake Place Nw

Rochester, MN55901 Olmsted County, 55

License Categories:

Expires on: //

Establishment Info:

ID #: 0038266

Risk:

Announced Inspection: No

Operator:

Phone #: 5072821550

ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

MISSING SIGN IN SERVICE AREA

Comply By: 05/21/24

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit

Location: Dishwasher Violation Issued: No

Chlorine: = at Degrees Fahrenheit

Violation Issued: No

Location:

Food and Equipment Temperatures

Process/Item: Walk-In Cooler

Temperature: 40 Degrees Fahrenheit - Location: Margrin

Violation Issued: No

Process/Item: Walk-In Freezer

Temperature: 0 Degrees Fahrenheit - Location: Hotdogs

Violation Issued: No

Process/Item: Hot Holding

Temperature: 165 Degrees Fahrenheit - Location: Soup

Violation Issued: No

Full Type: 05/21/24 Date: Time: 10:05:57 Report: 1038241057

Food and Beverage Estab	olishmen
Inspection Repor	t

iver Bend Assisted Living & M	
Process/Item: Hot Holding Temperature: 157 Degrees Fahrenheit - Location: Lasana Violation Issued: No	
Process/Item: Cooking Temperature: 168 Degrees Fahrenheit - Location: Hamburger Violation Issued: No	
Process/Item: Hot Holding Temperature: 168 Degrees Fahrenheit - Location: Ham Violation Issued: No	
Process/Item: Upright Cooler Temperature: 40 Degrees Fahrenheit - Location: Cream Violation Issued: No	
Process/Item: Upright Cooler Temperature: Degrees Fahrenheit - Location: Violation Issued: No	
Total Orders In This Report Priority 1 Priority 2 Priority 3 0 0 1	
olgren@avivaseriorliving.com	
OTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or terations.	
I acknowledge receipt of the Minnesota Department of Health inspection report number 1038241057 of 05/21/24.	
Certified Food Protection Manager Julie Quenzer	
Certification Number: FM33086 Expires: 05/23/27	
Signed: Signed:	-
Derek Olgren Rob Davis Sanitarian 2	

Rochester District Office 507-810-9902 rob.davis@state.mn.us