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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ 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 FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31368015-1 On September 23, 2024, through September 25, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 24, 2024. At the time of the survey, there were 66 residents; 57 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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: No further action required.	{0 480}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{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.	{0 800}		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and	{01370}		

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{01370}	Continued From page 3 (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on 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, ULP-P) to include all required content. 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	{01370}		

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{01370}	Continued From page 4 found to be pervasive). The findings include: ULP-C ULP-C was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of training for the following topics: - reports of changes in the resident's condition to the supervisor designated by the facility; - awareness of commonly used health technology equipment and assistive devices. ULP-C's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care. 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 lacked evidence of training for the following topics: - reports of changes in the resident's condition to the supervisor designated by the facility; - awareness of commonly used health technology equipment and assistive devices. ULP-E's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care; - care of teeth, gums, and oral prosthetic devices; - assisting with toileting.	{01370}		

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{01370}	Continued From page 5 ULP-N ULP-N was hired on November 14, 2023, to provide direct care and services to the facility's residents. ULP-N's employee record lacked evidence of training for the following topics: - reports of changes in the resident's condition to the supervisor designated by the facility; - awareness of commonly used health technology equipment and assistive devices. ULP-N's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - standby assistance techniques and how to perform them. ULP-O ULP-O was hired on July 3, 2024, to provide direct care and services to the facility's residents. ULP-O's employee record lacked evidence of training for the following topics: - understanding appropriate boundaries between staff and residents and the resident's family. ULP-O's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care. ULP-P ULP-P was hired on August 5, 2024, to provide direct care and services to the facility's residents.	{01370}		

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{01370}	Continued From page 6 ULP-P's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care and use of hearing aids; - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On September 25, 2024, at 11:00 a.m., registered nurse/consultant (RN/C)-Q stated the ULP employee records as noted above lacked evidence of the training and competencies as required. RN/C-Q indicated they had made changes to their competency forms a couple of different times but had not had all staff re-complete. RN/C-Q further indicated the most recent employees had received the required training and competencies. The licensee's Assisted Living Orientation-ULP Staff policy dated January 30, 2024, indicated staff would receiving the following training: 4. Training for ULP who are not NAR (nursing assistant registered) would receive training in the following topics with a written or oral competency test: c. Changes in condition i. observation ii. How and where to report n. Appropriate boundaries between staff, residents, and resident families o. Commonly used health technology equipment and assistive devices. 5. In addition to training all staff receive, ULP's who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill	{01370}		

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{01370}	Continued From page 7 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.	{01370}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on 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,	{01380}		

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{01380}	Continued From page 8 ULP-P) to include all required content. 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: ULP-C ULP-C was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of 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-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 lacked evidence of 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	{01380}		

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{01380}	Continued From page 9 appropriate personnel. ULP-N ULP-N was hired on November 14, 2023, to provide direct care and services to the facility's residents. ULP-N's employee record lacked evidence of 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-N's employee record lacked evidence of competency evaluation for: - safe transfer techniques and ambulation ULP-O ULP-O was hired on July 3, 2024, to provide direct care and services to the facility's residents. ULP-O's employee record lacked evidence of 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	{01380}		

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{01380}	Continued From page 10	{01380}		

respirations of the resident;
- safe transfer techniques and ambulation; and
- range of motioning and positioning;

On September 25, 2024, at 11:25 a.m., registered nurse/consultant (RN/C)-Q stated the ULP employee records as noted above lacked evidence of the training and competencies as required. RN/C-Q indicated they had made changes to their competency forms a couple of different times but had not had all staff re-complete. RN/C-Q further indicated the most recent employees had received the required training and competencies.

The licensee's Assisted Living Orientation-ULP Staff policy dated January 30, 2024, indicated staff would receiving the following training:
4. Training for ULP who are not NAR (nursing assistant registered) would receive training in the following topics with a written or oral competency test:
p. Observing, reporting, and documenting resident status
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.
5. In addition to training all staff receive, ULP's who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration:
k. Reading and recording temperature, pulse and respirations of the resident;
l. Safe transfer techniques and ambulation;
m. Range of motion;
n. Positioning.

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{01380}	Continued From page 11 No further information was provided.	{01380}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure PRN (as needed) medication had documentation of effectiveness after administration for three of three residents (R12, R13, 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).	{01760}		

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{01760}	Continued From page 12 The findings include: R12 R12's service plan dated July 19, 2024, indicated R12 received assistance with medication management. R12's signed prescriber orders dated July 12, 2024, included acetaminophen (for mild to moderate pain) 650 milligrams (mg) 2 tabs every 8 hours PRN (as needed). R12's September 1, 2024, through September 24, 2024, medication administration summary (MAR) identified the administration of the following: - September 1, 2024, (no time documented) PRN acetaminophen with no results documented. - September 3, 2024, (no time documented) PRN acetaminophen with no results documented. - September 4, 2024, (no time documented) PRN acetaminophen with no results documented. - September 5, 2024, (no time documented) PRN acetaminophen with no results documented. - September 6, 2024, (no time documented) PRN acetaminophen with no results documented. - September 7, 2024, at 9:31 p.m. PRN acetaminophen with no results documented. - September 18, 2024, at 9:59 p.m. PRN acetaminophen with no results documented. - September 19, 2024, at 8:56 p.m. PRN acetaminophen with no results documented. - September 20, 2024, at 12:00 a.m. PRN acetaminophen with no results documented. - September 21, 2024, at 10:33 p.m. PRN acetaminophen with no results documented. - September 22, 2024, (no time documented) PRN acetaminophen with no results documented. R13	{01760}		

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	31368	A. BUILDING: _____ 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

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{01760}	Continued From page 13 R13's service plan dated July 11, 2024, indicated R13 received assistance with medication management. R13's signed prescriber orders dated September 24, 2024, included acetaminophen 1000 mg every 6 hours PRN pain. R13's September 1, 2024, through September 24, 2024, MAR Summary identified the administration of the following: - September 2, 2024, at 8:33 p.m. PRN acetaminophen with no results documented. - September 3, 2024, at 8:24 p.m. PRN acetaminophen with no results documented. - September 5, 2024, at 8:44 p.m. PRN acetaminophen with no results documented. - September 6, 2024, at 5:44 p.m. PRN acetaminophen with no results documented. - September 13, 2024, at 10:51 p.m. PRN acetaminophen with no results documented. - September 15, 2024, (no time documented) PRN acetaminophen with no results documented. - September 16, 2024, at 8:21 p.m. PRN acetaminophen with no results documented. - September 17, 2024, at 8:37 p.m. PRN acetaminophen with no results documented. - September 18, 2024, at 5:39 p.m. PRN acetaminophen with no results documented. - September 19, 2024, (no time documented) PRN acetaminophen with no results documented. - September 20, 2024, at 9:01 p.m. PRN acetaminophen with no results documented. - September 21, 2024, at 9:12 p.m. PRN acetaminophen with no results documented. - September 23, 2024, at 5:49 p.m. PRN acetaminophen with no results documented. R6 R6's service plan dated August 9, 2024, indicated	{01760}		

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{01760}	Continued From page 14 R6 received assistance with medication management. R6's prescriber orders dated May 7, 2024, included diclofenac sodium 1% gel (for pain), apply 2 grams (gm) topically twice a day. May also apply 2 gm twice daily PRN (back pain). R6's September 1, 2024, through September 24, 2024, MAR Summary identified the administration of the following: - September 21, 2024, at 1:44 p.m. PRN diclofenac sodium gel administered with no results documented. On September 25, 2024, at 1:34 p.m. registered nurse/consultant (RN/C)-Q stated PRN effectiveness was lacking from R12, R13, and R6's records as noted above. RN/C-Q stated the ULP should have documented the time of administration and followed up with the resident after the PRN medication was given to see if it was effective or not. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated February 20, 2024, included the RN will provide specific instructions for administering PRN medications consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered. The PRN instructions will include the need and interval to monitor and report effectiveness to the RN. No further information was provided.	{01760}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	{01910}		

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{01910}	Continued From page 15 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 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the dosage and date for one of three discharged residents (R2). 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:	{01910}		

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{01910}	Continued From page 16 The licensee's Discharged or Deceased Resident Roster: State Evaluations form identified R2 expired on July 30, 2024. R2's Medication Disposition/Disposal Record form dated July 15, 2024, and August 20, 2024, had columns that identified the date, medication/dose/prescription number, quantity, method of disposition/disposal, and a nurse signature line. The following medications were listed without a dosage: vitamin B-12 (supplement) and carbidopa/l-DOPA (for Parkinson's); The following medication was listed without a date: carbidopa/l-DOPA. On September 24, 2024, at 10:08 a.m. registered nurse/consultant (RN/C)-Q stated R2's disposition form lacked the required information as noted above and had not been identified in an audit. RN/C-Q indicated a new form had been developed within the last week to ensure required components were not missed. The licensee's Disposition or Disposal of Medication policy dated February 20, 2024, noted: b. Documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information was provided.	{01910}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}		

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{02040}	Continued From page 17 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

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

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:

    i. 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

c. **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. <u>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</u>. 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.

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

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31368015-0 On May 20, 2024, through May 24, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 69 residents; 56 receiving services under the provider's Assisted Living with Dementia Care license. 2310: An immediate order was identified on May 21, 2024, at a level 3/Pattern (H). The immediacy was lifted on May 23, 2024, but the scope and level remains unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 20, 2024,	0 250		

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0 250	Continued From page 3 at 11:15 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent on December 1, 2023. The licensee had an assisted living license issued on January 31, 2024, with an expiration date of January 30, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff. (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) orientation to and implementation of the assisted living bill of rights; (5) conducting appropriate screenings, or documentation of prior screenings, to show that	0 250		

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0 250	Continued From page 6 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	0 250		
0 470 SS=F	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 safety needs. Such persons must be:	0 470		

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0 470	Continued From page 7 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was evaluated twice a year to ensure appropriate staffing levels. This had the potential to affect all residents and staff of the licensee. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's census was 69 residents, 56 of whom received services under the assisted living license. During the entrance conference on May 20, 2024, at 11:15 a.m. the licensee's staffing plan was requested. The licensee's staffing plan was received and dated reviewed on May 21, 2024, one day after	0 470		

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0 470	Continued From page 8 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	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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	0 480		

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0 480	Continued From page 9 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.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.	0 580		

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0 580	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630		

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0 630	Continued From page 11 individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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: R1 R1's diagnoses included dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). 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.	0 630		

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0 630	Continued From page 12 R1's Vulnerability and Safety assessment built into the Health and Service Evaluation assessment (identified as the IAPP) dated October 21, 2023, failed to include: -the person's risk of abusing other vulnerable adults; In addition, R1's IAPP indicated R1 was at risk to be abused. The licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects 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. R2's Vulnerability and Safety assessment built into the Health and Service Evaluation assessment (identified as the IAPP) dated April 30, 2024, failed to include: -the person's risk of abusing other vulnerable adults; In addition, R2's IAPP indicated R2 was not at risk to be abused. The licensee failed to recognize that R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement	0 630		

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0 630	Continued From page 13 interventions to minimize his abuse by others including other vulnerable adults. R4 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. 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;	0 630		

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0 630	Continued From page 14 R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with bathing, medication administration, housekeeping, and laundry. R6's Vulnerability and Safety assessment built into the Health and Service Evaluation assessment (identified as the IAPP) dated August 8, 2023, failed to include: - the person's risk of abusing other vulnerable adults; On May 23, 2024, at 11:11 a.m., registered nurse (RN)-B stated the risk of abusing other vulnerable adults was lacking from the residents' IAPPs as noted above. RN-B further stated R1's IAPP lacked interventions to minimize his abuse by others including other vulnerable adults and R2's IAPP should indicate that he was at risk to be abused and implement interventions to minimize his abuse. The licensee's Individual Abuse Protection Plans policy dated February 20, 2024, indicated the IAPP would include: - individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable adults; - specific measures to minimize the risk of abuse to that person and other vulnerable adults; and - measure to minimize the risk of self-abuse, if applicable. Abuse prevention plans will be reviewed every 90 days and revised as needed.	0 630		

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0 630	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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	0 660		

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0 660	Continued From page 16 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment dated March 20, 2024, indicated the licensee was "low risk". ULP-E began providing direct care service for the licensee on December 18, 2023. ULP-E's record contained a negative TB blood test dated December 4, 2023; however, ULP-E's employee record lacked a TB history and symptom screen. On May 23, 2024, at 12:10 p.m. licensed assisted living director (LALD)-A stated ULP-E was lacking a TB history and symptom screen. The licensee's TB Prevention and Control policy dated February 20, 2024, noted upon hire and prior to contact with residents, the registered nurse (RN) will review TB symptoms with each new assisted living employee and with any volunteers having direct resident contact. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may	0 660		

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0 660	Continued From page 17 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	0 660		
0 690 SS=F	144G.43 Subdivision 1 Resident record (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	0 690		

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

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0 690	Continued From page 18 R1's diagnoses included dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). 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. 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. R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects	0 690		

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0 690	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. R4 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	0 690		

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0 690	Continued From page 20 observed ULP-E check R4's blood sugar and administer his insulin. R4's MAR Summary dated May 1, 2024, through May 21, 2024, included staff initials but lacked staff names/signatures and credentials/title. R4's Monthly Task Log dated May 1, 2024, through May 21, 2024, included staff initials and name, but lacked staff credentials/title. R4's Health and Service Evaluation assessments dated September 12, 2023, December 6, 2023, and March 7, 2024, identified the staff name but lacked staff credentials/title. 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. On May 22, 2024, at 12:17 p.m. the surveyor observed ULP-K lock R5's wheelchair breaks, apply a gait belt, and transfer R5 into his recliner chair. R5's Monthly Task Log dated May 1, 2024, through May 21, 2024, included staff initials and name, but lacked staff credentials/title. R5's Fall Assessments dated December 11, 2023, and May 7, 2024, identified the staff name but lacked staff credentials/title.	0 690		

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0 690	Continued From page 21 R5's Incident Forms dated February 16, 2024, February 19, 2024, and February 24, 2024, identified the staff name but lacked staff credentials/title. R5's Progress Notes dated December 11, 2023, through May 21, 2024, identified the staff name but lacked staff credentials/title. R5's Health and Service Evaluation assessments dated December 11, 2023, December 27, 2023, and May 7, 2024, identified the staff name but lacked staff credentials/title. R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with bathing, medication administration, housekeeping, and laundry. On May 21, 2024, at 7:34 a.m. the surveyor observed ULP-E administer medications to R6. R6's MAR Summary dated May 1, 2024, through May 21, 2024, included staff initials but lacked staff names/signatures and credentials/title. R6's Monthly Task Log dated May 1, 2024, through May 21, 2024, included staff initials and name, but lacked staff credentials/title. R6's Progress Notes dated October 25, 2023, through May 3, 2024, identified the staff name but lacked staff credentials/title. R6's Health and Service Evaluation assessment dated August 8, 2023, identified the staff name but lacked staff credentials/title.	0 690		

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0 690	Continued From page 22 R7 R7's diagnoses included hypertension (high blood pressure). R7's Service Plan dated May 8, 2024, indicated R7 received assistance with bathing, toileting, dressing, mobility/ambulation, medication administration, housekeeping, laundry, bathing, medication administration, housekeeping, and laundry. On May 21, 2024, at 8:11 a.m. the surveyor observed ULP-L administer medications to R7. R7's MAR Summary dated May 1, 2024, through May 21, 2024, included staff initials but lacked staff names/signatures and credentials/title. On May 22, 2024, at 1:49 p.m., registered nurse/consultant (RN/C)-D stated for paper documents staff should have included their initials, name, signature, and title at the bottom of each page. RN/C-D further stated the electronic health record (EHR) system used for all residents was not set up to include the staff credentials/title for the identified documents listed above. On May 23, 2024, at 11:25 a.m. registered nurse (RN)-B stated the documents lacked staff names/signatures and credentials/titles as noted above. The licensee's Resident Records policy dated January 31, 2024, indicated resident record entries would be legible, permanently recorded, dated, and signed by the person making the entry. No further information was provided.	0 690		

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0 690	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 24 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included the required documentation of all provided services 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: R1, R2, R4, R5, and R6's records lacked documentation that all services were provided as scheduled. R1	0 730		

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0 730	Continued From page 25 R1's diagnoses included dementia. 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 Monthly Task Log dated May 1, 2024, through May 21, 2024, identified the unlicensed personnel (ULP) documented the services as follows: -grooming/personal hygiene: 35 out of 61 opportunities; -toileting 80 out of 103 opportunities; -dressing: 27 out of 41 opportunities; -trash removal: 20 out of 21 opportunities. R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects 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. R2's Monthly Task Log dated May 1, 2024, 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;	0 730		

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0 730	Continued From page 26 -encourage assistive hearing devices: 21 out of 41 opportunities. R4 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 daily, bathing twice weekly, dressing daily, toileting and grooming/personal hygiene three times per day, medication administration four times daily, mobility/ambulation daily, transferring daily, housekeeping daily, and laundry weekly. R4's Monthly Task Log dated May 1, 2024, through May 21, 2024, identified the ULP documented the services as follows: - grooming/personal hygiene: one out of 63 opportunities; - toileting: one out of 63 opportunities; - dressing: zero out of 21 opportunities; - mobility/ambulation: zero out of 21 opportunities; - bathing: one out of six opportunities; - laundry: zero out of three opportunities; - daily bed making: zero out of 21 opportunities; and - trash removal: one out of 42 opportunities 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) daily, dressing, grooming/personal	0 730		

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0 730	Continued From page 27 hygiene, mobility/ambulation three times daily, toileting three times daily, transferring three times daily, housekeeping daily, and laundry weekly. On May 22, 2024, at 12:17 p.m. the surveyor observed ULP-K lock R5's wheelchair breaks, apply a gait belt, and transfer R5 into his recliner chair. R5's Monthly Task Log dated May 1, 2024, through May 21, 2024, identified the ULP documented the services as follows: - dressing: 18 out of 42 opportunities; - grooming/personal hygiene: 20 out of 42 opportunities; - CPAP: four out of 21 opportunities; - daily bed making: 15 out of 21 opportunities; and - trash removal: 16 out of 21 opportunities. R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with bathing, medication administration, housekeeping, and laundry. R6's Monthly Task Log dated May 1, 2024, through May 21, 2024, identified the ULP documented the services as follows: - bathing: zero out of six opportunities. On May 22, 2024, at 11:55 a.m. ULP-E stated cares were completed but were not consistently documented. ULP-E indicated all cares completed should be documented. On May 23, 2024, at 11:32 a.m. registered nurse (RN)-B stated the ULP were not consistent with documenting the completion of services. RN-B	0 730		

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0 730	Continued From page 28 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: Twenty-one (21) days	0 730		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780		

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0 780	Continued From page 29 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements in two resident apartments. This had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: On May 24, 2024, at 9:00 a.m., survey staff toured the facility with maintenance director (MD)-H. During the tour, MD-H tested the smoke alarms installed in resident apartments and survey staff observed the following: 1. In resident apartment 109, when the living room smoke alarm was tested, the smoke alarm was not activated in bedroom 1. 2. In resident apartment 302, when the smoke alarms in bedrooms 1 and 2 were tested, the living room smoke alarm was not activated. The smoke alarms installed in the bedrooms and outside each sleeping area were not all interconnected in apartments 109 and 302. During the facility tour interview on May 24, 2024, at 9:00 a.m., MD-H verified these smoke alarms were not interconnected as required.	0 780		

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0 780	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	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: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 24, 2024, at 9:00 a.m., survey staff toured the facility with maintenance director (MD)-H. During the tour, survey staff observed	0 800		

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0 800	Continued From page 31 the following: 1. The spring hinges installed on the labeled 20-minute fire door leading from the corridor into resident dwelling unit 217 were not working properly, the door did not self-close and positively latch. All components of a fire door assembly must be maintained in proper working order During the facility tour interview on May 24, 2024, MD-H verified the spring hinges were not working properly and stated the hinges would be adjusted. 2. The labeled 20-minute fire doors with self-closing hinges were propped open with wedges for the second, third, and fourth floor laundry rooms. 3. Labeled 20-minute fire doors with self-closing hinges were propped open with kickdown door stops for the fitness center, theatre, and club room. Fire doors held open by a wedge or door stop will prohibit the required operation and closing feature of the door. 4. The exit door near the elevator equipment room had two holes in the panel. 5. The labeled 45 minute fire door leading into the main assisted living dining/living area had three holes near the top of the door. During the facility tour interview on May 24, 2024, MD-H verified the fire doors that were propped open and the holes in the doors. 6. Two extension cords were being used behind the front desk. 7. An extension cord was used for a light in the 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 use of extension cords creates a potential fire hazard. During the facility tour interview on May 24, 2024, MD-H verified these extension cords were not	0 800		

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	31368	A. BUILDING: _____ B. WING _____	05/24/2024

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0 800	Continued From page 32 used correctly. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=F	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). The findings include: On May 24, 2024, at 9:00 a.m., survey staff	0 820		

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0 820	Continued From page 33 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	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens;	01370		

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01370	Continued From page 34 (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-C and ULP-E) to include all required content. This practice resulted in a level two violation (a	01370		

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01370	Continued From page 35 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional -understanding appropriate boundaries between staff and residents and the resident's family -awareness of commonly used health technology equipment and assistive devices ULP-C's employee record lacked evidence of competency evaluation for the following: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing. ULP-E ULP-E was hired on December 18, 2023, to provide direct care and services to the facility's	01370		

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01370	Continued From page 36 residents. ULP-E's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -preparation of modified diets as ordered by a licensed health professional; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices; ULP-E's employee record lacked evidence of competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including: - hair care; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - assisting with toileting. On May 23, 2024, at 11:06 a.m., registered nurse (RN)-B stated ULP-C and ULP-E's record lacked evidence of the above training and competencies as required. The licensee's Assisted Living Orientation-ULP Staff policy dated January 30, 2024, indicated staff would receiving the following training: 4. Training for ULP who are not NAR (nursing assistant registered) would receive training in the following topics with a written or oral competency test: b. Documentation requirements for services provided c. Changes in condition	01370		

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01370	Continued From page 37 i. observation ii. How and where to report d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming g. Basic nutrition h. Meal preparation i. Food safety j. Assistance with eating k. Preparation of modified diets as ordered by a licensed health professional n. Appropriate boundaries between staff, residents, and resident families o. Commonly used health technology equipment and assistive devices No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 38 (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 two of two unlicensed personnel (ULP-C and ULP-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record lacked evidence of 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-E ULP-E was hired on December 18, 2023, to provide direct care and services to the facility's residents.	01380		

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01380	Continued From page 39 ULP-E's employee record lacked evidence of 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. On May 23, 2024, at 11:06 a.m., registered nurse (RN)-B stated ULP-C and ULP-E's record lacked evidence of the above training and competencies as required. The licensee's Assisted Living Orientation-ULP Staff policy dated January 30, 2024, indicated staff would receiving the following training: 4. Training for ULP who are not NAR (nursing assistant registered) would receive training in the following topics with a written or oral competency test: p. Observing, reporting, and documenting resident status 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	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470		

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01470	Continued From page 40 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470		

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01470	Continued From page 41 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-C ULP-C was hired on August 1, 2023, to provide direct care and services to the facility's residents. ULP-C's employee record did not include the	01470		

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01470	Continued From page 42 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 Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - 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	01470		

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01470	Continued From page 43 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 Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - review of the types of assisted living services the employee will be providing and the facility's category of licensure. On May 23, 2024, at 9:54 a.m., licensed assisted living director (LALD)-A stated ULP-C and ULP-E's records lacked the required orientation training. LALD-A further stated the owners were used to 'out of state' orientation requirements and had not assigned the required Minnesota orientation training for all staff. The licensee's Assisted Living and Assisted Living with Memory Care Orientation-All Staff policy dated January 30, 2024, indicated all employees would complete orientation to include the following topics: a. An overview of Minnesota's assisted living law b. An introduction and review of agency policies and procedures related to the provision of assisted living services e. The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights	01470		

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01470	Continued From page 44 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 -handling resident complaints -the facility's system for receiving and responding to complaints -where and how to report complaints -contact information for the Office of Health Facility Complaints -contact information for the Office of the Ombudsman for Long-Term Care -contact information for the Office of the Ombudsman for Mental Health and Disabilities No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 45 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for two of two residents (R2, R5) and ongoing resident reassessments that did not exceed 90 days for four of four residents (R5, R4, R6, R1). In addition, the licensee failed to complete change of condition assessment for one of one resident (R5) with multiple falls. 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).	01620		

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	31368	A. BUILDING: _____ B. WING _____	05/24/2024

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01620	Continued From page 46 The findings include: R2 R2 began receiving assisted living services on April 30, 2024. R2's Service Plan dated April 30, 2024, indicated R2 received assistance with dressing, bathing, toileting, mobility/ambulation, escorts, housekeeping, laundry, and medication management. 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. 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.	01620		

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01620	Continued From page 47 In addition, R5's record included a Health and Service Evaluation assessment dated May 7, 2024. The May 7, 2024 assessment was 132 days from the last date of the assessment on December 27, 2023, exceeding 90 calendar days. R4 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. R4's record included Health and Service Evaluation assessments dated September 12, 2023, December 6, 2023, and March 7, 2024. The March 7, 2024, assessment was 92 days from the last date of the assessment, exceeding 90 calendar days. R6 R6's Service Plan dated March 9, 2024, indicated R6 received assistance with bathing, medication administration, housekeeping, and laundry. R6's record included a Health and Service Evaluation assessment dated August 8, 2023. R6's record lacked evidence of additional comprehensive nursing assessments after the August 8, 2023, assessment had been completed. 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.	01620		

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01620	Continued From page 48 R1's record included a Health and Service Evaluation assessments dated August 23, 2023, and October 21, 2023. R1's record lacked evidence of additional comprehensive nursing assessments after the October 21, 2023, assessment had been completed. On May 23, 2024, at 11:16 a.m. registered nurse (RN)-B stated the above named assessments were late. RN-B further stated she was behind on the assessments and trying to get them caught up. CHANGE OF CONDITION R5 was admitted December 11, 2023, with diagnoses of cerebellar ataxia (disorder that affects balance and coordination). On May 22, 2024, at 12:17 p.m. the surveyor observed ULP-K lock R5's wheelchair breaks, apply a gait belt, and transfer R5 into his recliner chair. R5's service plan dated May 7, 2024, indicated R5 received assistance with continuous positive airway pressure (CPAP) machine, dressing, grooming/personal hygiene, mobility/ambulation, toileting, transferring, housekeeping, and laundry. R5's Health and Service Evaluation assessment dated May 7, 2024, identified the resident was dependent on staff members for all mobility/ambulation needs, required extensive assistance with transfers and or changes in position, had three or more falls in the last 90 days, and was a high potential for falls. R5's progress notes and incident reports noted	01620		

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01620	Continued From page 49 the following: -January 22, 2024, 1:30 p.m. R5's progress note included: Resident had two falls over the weekend, the first one Friday in the evening in his bathroom, denies hitting his head, no injuries. Resident did break his walker. Family notified and brought him a new walker. Sunday morning resident fell ambulating trying to get a depend (incontinent garment) out. Each fall resident has been bare footed, a pair of gripper socks provided, and resident reminded to use them. There was no incident report on either fall. - January 29, 2024, 9:15 a.m. R5's progress note included: Staff called nursing at 6:00 a.m. to report resident was found on the floor in his bedroom. Resident stated that he was self-transferring to the bathroom and fell on the way. No injuries. There was no incident report completed, and no new interventions or root cause was identified. - January 30, 2024, 9:29 a.m. R5's progress note included: Resident shows no ill effects from fall. -February 4, 2024, at 6:39 a.m. R5's progress note included: 5:00 a.m. resident's pendant was alarming, staff found resident on the floor. Resident stated he was self-transferring to the bathroom and fell next to his bed. No injuries. There was no incident report completed, and no new interventions or root cause was identified. -February 7, 2024, at 10:49 a.m. R5's progress note included: Resident has no ill effects from fall on 2/4/24. Family present this morning and declined vitals at this time. Nursing continues to observe. - February 10, 2024, at 3:39 p.m. progress note	01620		

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01620	Continued From page 50 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. 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 leg below knee. Reminded resident to use pendant when transferring.	01620		

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01620	Continued From page 51 Resident is more confused and hallucinating. Immediate action taken: assisted person to standing position, bandaged, cleansed area, staff assisted. A progress note was noted on February 27, 2024, at 12:56 p.m. which identified the above incident. No new interventions or root cause was identified. On May 22, 2024, at 10:20 a.m. registered nurse (RN)-B stated the director of nursing (who was no longer employed) had been in charge of reviewing falls. RN-B stated an incident report should be completed for each fall and interventions to prevent future falls should be identified. RN-B further stated there was no root cause of R5's falls identified, and no interventions related to R5's falls documented. The licensee's Initial and On-going Assessments of Residents policy dated February 20, 2024, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition. The licensee's Fall Management and Managing Fall Risk policy dated January 26, 2024, noted in the event of a fall: 7. An incident report will be completed in the electronic health record. This includes the entire investigation of the fall, and staff will attempt to identify the root cause of the fall.	01620		

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01620	Continued From page 52 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	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 by:	01650		

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01650	Continued From page 53 Based on interview and record review, the licensee failed to ensure the service plan included 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included dementia. 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. R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects 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	01650		

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01650	Continued From page 54 management. R4 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. 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, dressing, grooming/personal hygiene, mobility/ambulation, toileting, transferring, housekeeping, and laundry. R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with bathing, medication administration, housekeeping, and laundry. R1, R2, R4, R5, and R6's service plans lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - 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	01650		

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01650	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 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. 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 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; - 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; - circumstances in which emergency medical	01650		

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01650	Continued From page 56 services are not to be summoned; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (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	01700		

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01700	Continued From page 57 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for four of four residents (R1, R2, R4, R6) prior to providing medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on May 20, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A and registered nurse/consultant (RN/C)-D stated the licensee provided medication management services to their residents. R1 R1's diagnoses included dementia. R1's service plan dated October 26, 2023, indicated R1 received assistance with medication management. R1's signed prescriber orders dated April 22, 2024, included acetaminophen (pain), aspirin (heart health), calcium carbonate (heartburn), diclofenac sodium gel (joint pain), digoxin (heart failure), diltiazem (blood pressure), donepezil (dementia), mirtazapine (anxiety), omeprazole	01700		

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01700	Continued From page 58 (reflux), miralax (constipation), potassium chloride (supplement), quetiapine (anxiety), ramelteon (insomnia), senokot (constipation) and torsemide (diuretic). On May 21, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Health and Service Evaluation assessment dated October 21, 2023, included a Medication Assessment section and a Medication Management Section. The assessment indicated R1 required total assistance with medication management and that a RN had completed a medication review of each of the resident's prescriptions, over-the-counter medications, and supplements. However, R1's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). R2's service plan dated April 30, 2024, indicated R2 received assistance with medication management. R2's signed prescriber orders dated April 30, 2024, included acetaminophen (pain), carbidopa-levodapa (tremors), vitamin B-12,	01700		

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01700	Continued From page 59 donepezil (dementia), finasteride (prostate), melatonin (sleep), naproxen sodium (pain), oxycodone (pain), miralax (constipation), quetiapine (Parkinson's disease), trospium (overactive bladder), biotene (dry mouth), morphine sulfate (pain), and lorazepam (anxiety). On May 21, 2024, at 1:27 p.m., the surveyor observed ULP-C administer medications to R2. R2's Health and Service Evaluation assessment dated April 30, 2024, included a Medication Assessment section and a Medication Management Section. The assessment indicated R2 required total assistance with medication management and that a RN had completed a medication review of each of the resident's prescriptions, over-the-counter medications, and supplements. However, R2's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R4 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 assistance with medication administration. R4 lacked prescriber orders. On May 21, 2024, at 7:12 a.m. the surveyor observed ULP-E check R4's blood sugar and administer his insulin.	01700		

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	31368	A. BUILDING: _____ B. WING _____	05/24/2024

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01700	Continued From page 60 R4's Health and Service Evaluation assessment dated March 7, 2024, included a Medication Assessment section and a Medication Management section. The assessment indicated R4 required total assistance with medication management and that a RN had completed a medication review of each of the resident's prescriptions, over-the-counter medications, and supplements. However, R4's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with medication administration. R6's prescriber orders dated May 7, 2024, included one for pain, five supplements, two for blood pressure, two for allergies, two skin ointments, one topical pain gel, one for memory, one for depression, one hormone cream, two for cholesterol, one pain patch, one for gastric reflux, and one for overactive bladder. On May 21, 2024, at 7:34 a.m. the surveyor observed ULP-E administer medications to R6. R6's Health and Service Evaluation assessment dated August 8, 2023, included a Medication Assessment section and a Medication Management section. The assessment indicated R6 required total assistance with medication management and that a RN had completed a	01700		

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01700	Continued From page 61 medication review of each of the resident's prescriptions, over-the-counter medications, and supplements. However, R6's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On May 23, 2024, at 11:26 a.m. registered nurse (RN)-B stated R1, R2, R4, and R6's records lacked a medication management assessment to include the required components as noted above. In addition, RN-B stated the same medication assessment was used for all residents. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record dated January 26, 2024, noted prior to providing medication management services the RN will review all medications the resident is known to be taking. This review must include indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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01730	Continued From page 62 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an	01730		

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01730	Continued From page 63 individualized medication management plan with the required content for four of four residents (R1, R2, R4, 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 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: During the entrance conference on May 20, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A and registered nurse/consultant (RN/C)-D stated the licensee provided medication management services to their residents. R1 R1's diagnoses included dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). R1's service plan dated October 26, 2023, indicated R1 received assistance with medication management. On May 21, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's signed prescriber orders dated April 22, 2024, included acetaminophen (pain), aspirin (heart health), calcium carbonate (heartburn), diclofenac sodium gel (joint pain), digoxin (heart failure), diltiazem (blood pressure), donepezil	01730		

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01730	Continued From page 64 (dementia), mirtazapine (anxiety), omeprazole (reflux), miralax (constipation), potassium chloride (supplement), quetiapine (anxiety), ramelteon (insomnia), senokot (constipation) and torsemide (diuretic). R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). R2's service plan dated April 30, 2024, indicated R2 received assistance with medication management. On May 21, 2024, at 1:27 p.m., the surveyor observed ULP-C administer medications to R2. R2's signed prescriber orders dated April 30, 2024, included acetaminophen (pain), carbidopa-levodapa (tremors), vitamin B-12, donepezil (dementia), finasteride (prostate), melatonin (sleep), naproxen sodium (pain), oxycodone (pain), miralax (constipation), quetiapine (Parkinson's disease), trospium (overactive bladder), biotene (dry mouth), morphine sulfate (pain), and lorazepam (anxiety). R4 R4's diagnoses included diabetes, congestive heart failure, and low back pain. R4's unsigned, Service Plan dated March 27, 2024, indicated R4 received assistance with medication administration.	01730		

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01730	Continued From page 65 R4 lacked prescriber orders. On May 21, 2024, at 7:12 a.m. the surveyor observed ULP-E check R4's blood sugar and administer his insulin. R6 R6's diagnoses included dementia. R6's Service Plan dated March 9, 2024, indicated R6 received assistance with medication administration. R6's prescriber orders dated May 7, 2024, included one for pain, five supplements, two for blood pressure, two for allergies, two skin ointments, one topical pain gel, one for memory, one for depression, one hormone cream, two for cholesterol, one pain patch, one for gastric reflux, and one for overactive bladder. On May 21, 2024, at 7:34 a.m. the surveyor observed ULP-E administer medications to R6. R1, R2, R4, and R6's records lacked evidence of a medication management plan to include: - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting mediation administration, verifications that all medications are administered	01730		

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01730	Continued From page 66 as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. On May 23, 2024, at 11:26 a.m. registered nurse (RN)-B stated R1, R2, R4, and R6's records lacked a medication management plan to include the required components as noted above. In addition, RN-B stated the same medication management plan was used for all residents. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record dated January 26, 2024, noted following the completion of the nursing assessment, including an assessment of the resident's needs for medication management, the RN develops an individualized medication management plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: c. identification of any specific resident instructions regarding medications our facility staff will administer; d. identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis; e. identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; f. procedure for staff to notify the licensed nurse there is a problem with any medication management service; and g. any resident specific requirements relating to the documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent complications or adverse reactions.	01730		

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01730	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of four residents (R2). In addition, the licensee failed to ensure PRN (as needed) medication had documentation of effectiveness after administration for one of four residents (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) and was issued at an isolated scope (when one or a limited number of	01760		

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01760	Continued From page 68 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: MEDICATIONS NOT ADMINISTERED AS PRESCRIBED R2 R2's diagnoses included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). R2's service plan dated April 30, 2024, indicated R2 received assistance with medication management. On May 21, 2024, at 1:27 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's signed prescriber orders dated April 30, 2024, included acetaminophen (pain), carbidopa-levodapa (tremors), vitamin B-12, donepezil (dementia), finasteride (prostate), melatonin (sleep), naproxen sodium (pain), oxycodone (pain), miralax (constipation), quetiapine (Parkinson's disease), trospium (overactive bladder), biotene (dry mouth), morphine sulfate (pain), and lorazepam (anxiety). R2's Medication Administration Record (MAR) Summary dated May 2024, identified the following: -On May 1, 2024, the following medications lacked documentation of being administered:	01760		

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01760	Continued From page 69 -acetaminophen (8 p.m. dose) -carbidopa-levodopa (2 p.m. and 8 p.m. dose) -finasteride -melatonin -quetiapine -trospium -On May 2, 2024, the following medication lacked documentation of being administered: -miralax -vitamin B-12 -On May 12, 2024, the following medication lacked documentation of being administered: -acetaminophen (8 p.m. dose) -carbidopa-levodopa (8 p.m. dose) -finasteride -melatonin -quetiapine -trospium On May 22, 2024, at 1:47 p.m., registered nurse/consultant (RN/C)-D stated R2's record lacked documentation of medication administration as listed above. RN/C-D further stated staff should document any refusal of medication, or the reason why a medication was not administered. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated February 20, 2024, indicated staff would document each task immediately after that task had been performed. It further stated documentation would follow professional standards for documentation. LACK OF PRN EFFECTIVENESS R6's Service Plan dated March 9, 2024, indicated R6 received assistance with medication administration.	01760		

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01760	Continued From page 70 R6's prescriber orders dated May 7, 2024, identified diclofenac sodium 1% gel (for pain), apply 2 grams (gm) topically twice a day. May also apply 2 gm twice daily PRN (back pain). R6's May 1, 2024, through May 21, 2024, MAR Summary identified the administration of the following: - May 1, 2024, at 7:00 a.m. PRN diclofenac sodium gel administered with no results documented. - May 7, 2024, at 7:00 a.m. PRN diclofenac sodium gel administered with no results documented. - May 8, 2024, at 7:00 a.m. PRN diclofenac sodium gel administered with no results documented. - May 17, 2024, at 7:00 a.m. PRN diclofenac sodium gel administered with no results documented. On May 23, 2024, at 11:56 a.m. RN-B stated PRN effectiveness was lacking from R6's record as noted above. RN-B stated ULP should follow up with the resident 30-60 minutes after the PRN medication is given to see if it was effective or not. RN-B further stated ULP should document the effectiveness of the medication on the MAR. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated February 20, 2024, included the RN will provide specific instructions for administering PRN medications consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered. The PRN instructions will include the need and interval to monitor and report effectiveness to the RN.	01760		

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01760	Continued From page 71 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions 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 for one 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 or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LACK OF PRESCRIPTION ORDERS	01820		

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01820	Continued From page 72 R4's unsigned, Service Plan dated March 27, 2024, indicated R4 received assistance with medication administration. R4's Medication Administration Record (MAR) Summary dated May 2024, included Lantus (long-acting insulin) 30 units subcutaneously once daily. On May 21, 2024, at 7:12 a.m. the surveyor observed ULP-E check R4's blood sugar and administer his insulin. R4 lacked prescriber orders. On May 23, 2024, at 11:35 a.m. registered nurse (RN)-B stated R4 lacked prescriber orders. RN-B stated there should be signed prescriber orders for all medications and treatments managed by the licensee. FREQUENCY OF MEDICATION ORDER R7's Service Plan dated May 8, 2024, indicated R7 received assistance with medication administration. R7's MAR Summary dated May 2024, included Vitamin D3 25 micrograms (1000 units) one tablet by mouth one time per day. On May 21, 2024, at 8:11 a.m. ULP-L was observed to administer medications to R7, including Vitamin D3 25 mcg. R7's prescriber orders dated May 8, 2024, included Vitamin D3 25 micrograms (1,000 units) by mouth. R7's Vitamin D3 order lacked a frequency. On May 23, 2024, at 11:35 a.m. RN-B stated R7's	01820		

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01820	Continued From page 73 Vitamin D3 prescriber order lacked a frequency. RN-B stated each medication order should include the medication name, dosage, route, and frequency. RN-B stated the order needed to be clarified with the provider. DISCONTINUED MEDICATION R1's diagnoses included dementia. R1's service plan dated October 26, 2023, indicated R1 received assistance with medication management. On May 21, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1. R1's signed physician orders dated February 7, 2024, included an order for metoprolol succinate 25 milligrams (mg) by mouth daily and latanoprost 0.006% ophthalmic solution; instill one drop in each eye every evening. R1's MAR Summary dated May 2024, lacked metoprolol succinate and latanoprost. On May 22, 2024, at 12:29 p.m., licensed practical nurse (LPN)-F stated metoprolol succinate and latanoprost had been discontinued. LPN-F further stated R1's record lacked a prescriber order to discontinue the medication. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy dated January 26, 2024, indicated the licensed nurse will request a prescription for all legend and over the counter medications and dietary supplements that our facility will be managing. The licensee's Implementing Changes in	01820		

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	31368	A. BUILDING: _____ B. WING _____	05/24/2024

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01820	Continued From page 74 Medication and Treatment Orders policy dated January 26, 2024, noted all changes in the resident's medication or treatment orders will be implemented in a timely and effective manner. 1. Residents will be asked to see the nurse upon return from any medical visit. 2. The RN/LPN will request an update from the resident or resident's family and will make a copy of any paperwork given to the resident by the medical providers. 3. The paperwork will be reviewed for changes or additions to the resident's medication or treatment orders. 6. All orders must be implemented within 24 hours of receipt of the order. 10. The RN/LPN will obtain the prescriber's signature on any verbal order as soon as possible. All actions taken to obtain the prescriber's signature will be documented in the resident's medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially	01880		

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01880	Continued From page 75 constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents residing in memory care. 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: On May 21, 2024, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-C preparing medications for a resident. ULP-C left the medication cart unlocked while she brought medications to the resident's room. On May 21, 2024, at 8:35 a.m., the surveyor observed an unlocked medication cart with no staff present for approximately five minutes. -when ULP-C returned to the medication cart, the surveyor inquired if the medication cart should be locked when unattended, and ULP-C stated she always locked it but must have forgotten. On May 21, 2024, at 1:20 p.m., the surveyor observed an unlocked medication cart with no staff present. Six residents were in the common living area with the unlocked medication cart. On May 22, 2024, at 1:41 p.m., registered nurse/consultant (RN/C)-D stated the medication cart should be locked when unattended.	01880		

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01880	Continued From page 76 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. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's	01910		

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01910	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 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 (RN/C)-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. RN/C-D further stated R3's medications were given to R3's family member which should have been documented with the family member's signature, but it was	01910		

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01910	Continued From page 78 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 medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 79 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R4, R5, 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 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: During the entrance conference on May 20, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A and registered nurse/consultant (RN/C)-D stated the licensee provided treatment management services to their residents. R4 R4's diagnoses included diabetes, congestive heart failure, and low back pain.	01940		

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01940	Continued From page 80 R4's unsigned, Service Plan dated March 27, 2024, indicated R4 received services including assistance with assistance with boot and brace. R4's service plan did not identify TED (thrombo-embolic deterrent) sock (compression socks used to increase circulation to prevent swelling). 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. R4's records lacked a treatment management plan to include the following required content for the use of compression stockings: - 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 a problem arose with treatments or therapy services; and	01940		

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01940	Continued From page 81 - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. 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. R5's service plan did not identify TED socks. R5 lacked prescriber orders for the CPAP machine and TED socks. On May 20, 2024, at 3:22 p.m. R5 was observed wearing bilateral TED socks. R5 stated staff put them on in the morning and remove them at night. In addition, R5 stated staff assist him with CPAP placement at night. R5's Monthly Task Log dated May 1, 2024, through May 21, 2024, included CPAP at night and TED stockings on in the morning, off in the evening. R5's records lacked a treatment management plan to include the following required content for the use of compression stockings: - 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 ULP;	01940		

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01940	Continued From page 82 - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R1 R1's diagnoses included dementia. 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 service plan did not include weekly weights. 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	01940		

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01940	Continued From page 83 a problem arose with treatments or therapy services; and - any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 23, 2024, at 11:43 a.m. RN-B stated R4, R5, and R1's record lacked a treatment management plan to include all the required content as noted above. The licensee's Development of the Individualized Treatment or Therapy Management Plan policy dated January 26, 2024, indicated a RN would develop an individualized treatment management plan for the resident in accordance with physician orders and in conjunction with the resident and/or the resident's representative. The plan would address: a. identification of the treatment or therapy management services to be provided by our facility; b. identification of any specific resident instructions regarding the treatments or therapy our facility staff will administer; c. identification of the staff who are responsible for the treatment or therapy management tasks, including tasks delegated to unlicensed staff; d. procedure for staff to notify the licensed nurse there is a problem with any treatments or therapy management service; e. any resident-specific requirements relating to documentation of treatments or therapy administration, verification that all treatments are administered as prescribed and monitoring of treatments or therapies to prevent possible	01940		

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01940	Continued From page 84 complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee 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:	01960		

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01960	Continued From page 85 R1 R1's diagnoses included dementia. 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 service plan did not include weekly weights. 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. -On May 4, 2024, R1's weight was documented as 180 pounds (lbs). -On May 11, 2024, the space to document the completion of R1's weight was left blank. -On May 18, 2024, R1's weight was documented as 174 lbs. On May 22, 2024, at 10:29 a.m., licensed practical nurse (LPN)-J stated R1's record lacked documentation of why his weight was not taken or documented on May 11, 2024. LPN-B further stated R1's primary provider should have been notified of the six-pound weight loss but could not find evidence in R1's record of the provider being notified. R4 R4's diagnoses included diabetes, congestive heart failure, and low back pain. R4's unsigned, Service Plan dated March 27,	01960		

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01960	Continued From page 86 2024, indicated R4 received services including assistance with assistance with a boot and brace, bathing, dressing, grooming/personal hygiene, toileting, medication administration, mobility/ambulation, transferring, housekeeping, and laundry. R4's service plan did not identify TED (thrombo-embolic deterrent) sock (compression socks used to increase circulation to prevent swelling) or blood sugar checks. On May 21, 2024, at 7:12 a.m. the surveyor observed unlicensed personnel (ULP)-E check R4's blood sugar and administer his insulin. 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. ULP-E stated R1 required assistance to apply the TED stocking, AFO brace, and Darco shoe/boot daily. R4 lacked prescriber orders. R4's Monthly Task Log dated May 1, 2024, through May 21, 2024, lacked documentation of TED stocking, AFO brace, or Darco shoe/boot assistance. On May 23, 2024, at 11:43 a.m., RN-B stated ULP should be documenting the completion of all services and treatments provided. RN-B stated R4's record lacked documentation of the TED stocking, AFO brace, and Darco shoe/boot assistance. The licensee's Development of the Individualized Treatment or Therapy Management Plan policy dated January 26, 2024, indicated treatment or	01960		

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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	144G.72 Subd. 6 Treatment and therapy orders 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 or 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:	01970		

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01970	Continued From page 88 During the entrance conference on May 20, 2024, at 11:15 a.m. licensed assisted living director (LALD)-A and registered nurse/consultant (RN/C)-D stated the licensee provided treatment management services to their residents. R4 R4's diagnoses included diabetes, congestive heart failure, and low back pain. R4's unsigned, Service Plan dated March 27, 2024, indicated R4 received services including assistance with assistance with a boot and brace. R4's service plan did not identify TED (thrombo-embolic deterrent) sock (compression socks used to increase circulation to prevent swelling) or blood sugar checks. On May 21, 2024, at 7:12 a.m. the surveyor observed unlicensed personnel (ULP)-E check R4's blood sugar and administer his insulin. 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. ULP-E stated R1 required assistance to apply the TED stocking, AFO brace, and Darco shoe/boot daily. R4's Health and Service Evaluation assessment dated March 7, 2024, indicated staff assisted R4 with TED stockings and required blood sugar testing and monitoring. The assessment did not identify R4 required an AFO to his left leg or Darco shoe/boot on his right foot. R4's medication administration record (MAR)	01970		

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01970	Continued From page 89 summary dated May 1, 2024, through May 21, 2024, included documentation of blood sugar checks four times a day. R4's Monthly Task Log dated May 1, 2024, through May 21, 2024, lacked documentation of TED stocking, AFO brace, or Darco shoe/boot assistance. R4 lacked prescriber orders. 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. R5's service plan did not identify TED socks. On May 20, 2024, at 3:22 p.m. R5 was observed wearing bilateral TED socks. R5 stated staff put them on in the morning and remove them at night. In addition, R5 stated staff assisted him with CPAP placement at night. R5's Health and Service Evaluation assessment dated May 7, 2024, did not identify R5 required TED socks or CPAP placement at night. R5's Monthly Task Log dated May 1, 2024, through May 21, 2024, included CPAP every night and TED socks on in the morning off in the evening. R5 lacked prescriber orders for the CPAP machine and TED socks. On May 23, 2024, at 11:43 a.m. RN-B stated both R4 and R5's record lacked prescriber orders for the treatments completed by staff each day as identified above. RN-B further stated there	01970		

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01970	Continued From page 90 should be prescriber orders for treatments. The licensee's Development of the Individualized Treatment or Therapy Management Plan policy dated January 26, 2024, indicated the RN would be responsible for requesting/receiving physician orders for treatments or therapies. The RN would be responsible for communicating with the prescriber on an as needed basis for changes or updates on the resident's response to the treatment or therapy provided. Treatment or therapies are physician ordered and include but are not limited to: - glucometer use and monitoring - CPAP - TED socks No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 91 by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all dementia care residents and staff. 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). Findings include: On May 24, 2024, maintenance director (MD)-H and licensed assisted living director (LALD)-A provided documents for review. A hazard and vulnerability assessment completed as part of the emergency preparedness plan for natural, technological, and human hazards was provided. Additionally, an annual hazard vulnerability assessment had been completed which identified safety risks to residents, but mitigation of these safety risks was not included. An assessment of the physical environment identifying safety risks or hazards on and around the property with mitigation factors for an assisted living facility with a secured dementia care unit had not been completed. During an interview, on May 24, 2024, at 12:40 p.m. MD-H and LALD-A verified the completed assessments did not meet the statute requirements.	02040		

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02040	Continued From page 92 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 20, 2024, at approximately 11:15 a.m., licensed assisted living director (LALD)-A stated the memory care	02140		

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02140	Continued From page 93 manager (MCM)-I oversaw the staff training in the care of individuals with dementia. On May 23, 2024, at 8:31 a.m., MCM-I stated he had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care. MCM-I further stated he was scheduled to complete the required training the following week. The licensee's Assisted Living with Memory Care Dementia Training policy dated January 1, 2024, indicated the supervisor providing or overseeing staff training would complete training equivalent to the requirements in this section and successfully pass a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be	02170		

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02170	Continued From page 94 developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1 and R2) who received services under the assisted living with dementia care license and resided in the secure memory care unit. 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	02170		

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02170	Continued From page 95 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. R2	02170		

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02170	Continued From page 96 R2 was admitted on April 30, 2024, with diagnoses that included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). On May 21, 2024, at 1:27 p.m., the surveyor observed ULP-C administer medications to R2. R2's service plan dated April 30, 2024, indicated R2 received assistance with dressing, bathing, toileting, mobility/ambulation, escorts, housekeeping, laundry, and medication management. R2's Lifetime Memoir dated May 7, 2024, indicated past and current interests. R2'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 R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On May 21, 2024, at 1:04 p.m., memory care manager (MCM)-I stated the Lifetime Memoir was the activity assessment used for all residents in memory care. MCM-I further stated he was not aware of the six provisions of the activity evaluation or that an individualize activity plan was required.	02170		

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02170	Continued From page 97 The licensee's Description of Life Enrichment Programs and How Activities are Implemented in ALDC policy dated February 20, 2024, indicated: 1. Each resident would be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for	02310		

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02310	Continued From page 98 one of two residents (R2) with hospital-style side rails. In addition, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for two of two residents (R5, R4) with assistive devices (consumer purchased side rail). This resulted in an immediate order on May 21, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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: HOSPITAL SIDE RAIL R2 R2 was admitted on April 30, 2024, with diagnoses that included Lewy Body Dementia (a progressive dementia that results from protein deposits in nerve cells of brain. It affects movement, thinking skills, mood, memory, and behavior), and Parkinson's Disease (disorder of the central nervous system that affects 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 20, 2024, at 3:22 p.m., R2's room was	02310		

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02310	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 R2's side rail met the Food and Drug Administration (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, toileting, transferring, housekeeping, and laundry. R5's Health and Service Evaluation assessment dated May 7, 2024, noted:	02310		

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02310	Continued From page 100 - bilateral side rails on hospital bed; - used side rails for bed mobility or other functional assistance only; - side rails or other supportive device has been checked and are sturdy and in good condition; - risks and benefits for use of side rails or other supportive device had been discussed with resident and/or resident's representative. R5's record lacked manufacturer's guidelines for installation and use of the consumer purchased side rails and lacked evidence the licensee referred to the Consumer Product Safety Commission (CPSC) for side rail recall information. R4 On May 21, 2024, at 7:12 a.m., the surveyor observed a square shaped consumer purchased side rail on the right upper side of R4's full sized bed that tucked under the mattress. R4's diagnoses included diabetes, congestive heart failure, and low back pain. R4's unsigned, service plan dated March 27, 2024, indicated R4 received services including assistance with bathing, dressing, grooming/personal hygiene, medication administration, mobility/ambulation, transferring, housekeeping, and laundry. R4's Health and Service Evaluation assessment dated March 7, 2024, noted: - resident uses side rail or other supportive device; - used side rails for bed mobility or other functional assistance only; - side rails or other supportive device has been checked and are sturdy and in good condition;	02310		

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02310	Continued From page 101 - risks and benefits for use of side rails or other supportive device had been discussed with resident and/or resident's representative. R4's record lacked manufacturer's guidelines for installation and use of the consumer purchased side rails and lacked evidence the licensee referred to the CSPC for side rail recall information. On May 21, 2024, at 9:35 a.m. RN/C-D stated both R5 and R4 had consumer purchased side rails on their respective beds (not a hospital bed as identified in R5's assessment). RN/C-D stated she had recommended the licensee check for recall and include the manufacturer's instructions for the consumer purchased side rails but was unable to find that in R5 and R4's record. The licensee's Assessing the Safety of Side Rails policy, undated, indicated the following: 1. At the time of move in, hospital return, change in condition, discovery of a rail, or if the resident expresses a desire to use a device the nurse with complete a device-equipment assessment in the electronic health record (EHR) the resident to determine the appropriateness of the device. 2. The licensed nurse or designee will review the risks and benefits of device use with the resident and/or family. 3. If the device is used on a bed, it will be reviewed for safety using FDA guidelines. If the RN determines that the side rails are not a safe device for the client, the RN will provide options and alternatives for reducing fall or positioning self to the client, the client's representative and/or the client's family. The RN will document these recommended options and the response from the client, client's family, and client's representative to the RN's recommendations.	02310		

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

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02310	Continued From page 102 4. If a side rail or other device is placed on a facility owned bed it will be installed according to manufacturer's instructions. 5. Documentation will be entered in the residents' record to include: results of the assessment, discussion with resident/family regarding risks and benefits, and decision made/outcome of discussion. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 103 - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed as evidenced by supervisor review on May 23, 2024; however, noncompliance remains at a level three, pattern (H).	02310		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

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

Food and Beverage Establishment Inspection Report

Location:
River Bend Assisted Living & M
30 Silver Lake Place Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0038266
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

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
Location:
Violation Issued: No

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

Type: Full
Date: *05/21/24*
Time: 10:05:57
Report: 1038241057
River Bend Assisted Living & M

Food and Beverage Establishment Inspection Report

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

dolgren@avivaseriorliving.com

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038241057 of 05/21/24.

Certified Food Protection Manager: Julie Quenzer

Certification Number: FM33086 Expires: 05/23/27

Signed: _____
Derek Olgren

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us