



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 18, 2024

Licensee
River of Life Residential, LLC
45 Battle Creek Road
Saint Paul, MN 55119

RE: Project Number(s) SL30129015

Dear Licensee:

On June 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 21, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 23, 2024

Licensee
River Of Life Residential, LLC
45 Battle Creek Road
Saint Paul, MN 55119

RE: Project Number(s) SL30129015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

An equal opportunity employer.

Letter ID: IS7N REVISED

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:

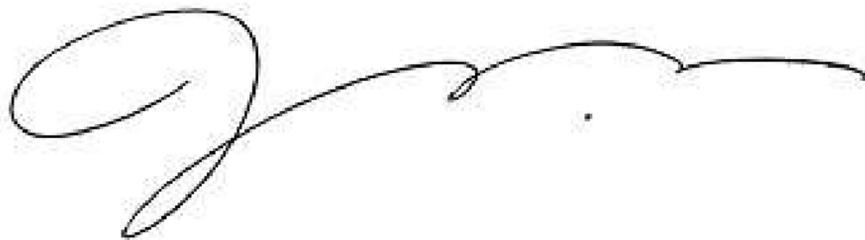
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a large initial 'J' and a long horizontal flourish.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2024
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NAME OF PROVIDER OR SUPPLIER RIVER OF LIFE RESIDENTIAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BATTLE CREEK ROAD SAINT PAUL, MN 55119
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: SL30129015</p> <p>On March 18, 2024, through March 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license.</p>	0 000	<p>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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the</p>	0 480		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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0 480	<p>Continued From page 1</p> <p>following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 580 SS=F	<p>144G.42 Subd. 2 Quality management</p> <p>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</p>	0 580		

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0 580	<p>Continued From page 2</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all residents receiving assisted living services.</p> <p>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).</p> <p>The findings include:</p> <p>On March 18, 2024, at 11:00 a.m., a request was made to review the licensee's quality management plan, but no plan was provided by the licensee.</p> <p>On March 20, 2024, at 11:00 a.m., licensed assisted living director (LALD)-C stated they haven't documented quality of management meetings a while, especially since they have undergone changes in nursing staffing. Also,</p>	0 580		
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0 580	<p>Continued From page 3</p> <p>LALD-C stated the new director support personnel (DSP) is in process of redeveloping the quality management plan to comply with Minnesota statute requirements.</p> <p>The license's Quality Management policy dated August 1, 2021, indicated "[Licensee] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 580		
0 650 SS=D	<p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place</p>	0 650		

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0 650	<p>Continued From page 4</p> <p>and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP-B, ULP-D)).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B started employment on December 6, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.</p> <p>ULP-D started employment on October 7, 2023, to provide assisted living services.</p> <p>ULP-B and ULP-D's records lacked documented evidence of the following: -training and competency for appropriate and safe techniques in personal hygiene and grooming, including: hair care, bathing, care of teeth, gums, oral prosthetic devices, and dressing and assisting with toileting; -training and competency for maintenance of a</p>	0 650		
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0 650	<p>Continued From page 5</p> <p>clean and safe environment; -training and competency for standby assistance techniques and how to perform them; -training and competency for range of motioning and positioning; -current job description; and -competency for Hoyer lift with one staff transfer.</p> <p>On March 19, 2024, at 2:00 p.m., ULP-B stated they recalled receiving training on the previously listed topics from the registered nurse (RN).</p> <p>On March 20, 2024, at 11:30 a.m., licensed assisted living director (LALD)-C stated the training and competency had been completed for ULP-B and ULP-D, but they were unable to locate the content listed above since the basement office was being remodeled. Also, RN-A stated she had been informed that the previous nurse had completed all the required training and competency for ULPs. RN-A provided documentation of Hoyer lift training, but the document indicated a two-person transfer. RN-A stated she observed and checked off only one person, and RN-A acknowledged they do not have documentation for one-person Hoyer transfer.</p> <p>The licensee's undated Employee Records policy noted the employee record would include records of all training provided and current signed job description, which includes qualifications, and responsibilities.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		
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0 680	Continued From page 6	0 680		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) containing all the requirements outlined in Appendix Z.</p> <p>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</p>	0 680		

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0 680	<p>Continued From page 7</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's EPP lacked a customized emergency preparedness plan reviewed/updated annually which included:</p> <ul style="list-style-type: none"> - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: <ul style="list-style-type: none"> - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: <ul style="list-style-type: none"> - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management 	0 680		
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0 680	<p>Continued From page 8</p> <p>agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy.</p> <p>During an interview on March 20, 2024, at approximately 12:00 p.m., licensed assisted living director (LALD)-C stated staff were familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which included the emergency preparedness guidelines) and LALD-C acknowledged the licensee had not fully developed and implemented an emergency preparedness plan/program.</p> <p>No further information was provided.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) Days</p>	0 680		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee</p>	0 800		

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0 800	<p>Continued From page 9</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>On March 19, 2024, at 10:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-C. During the facility tour, survey staff observed the following:</p> <ol style="list-style-type: none"> 1. The egress window in occupied resident bedroom two was opened and measured by LALD-C. The clear open width measured nineteen inches. The egress window opening appeared to be obstructed by window hardware. A clear open width of at least twenty inches was not provided. All paths of egress must provide unobstructed exiting. On March 19, 2024, at 3:45 p.m., survey staff completed a second tour of resident bedroom two. The egress window was opened and measured by LALD-C, the clear open area measured twenty-one inches in width and forty-six inches in height. During an interview on March 19, 2024, at 3:45 p.m., LALD-C verified the egress window was not properly maintained and had been obstructed by window hardware during the facility tour earlier that day. 2. An exit sign was posted over the door leading into the attached garage from the home. 	0 800		
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0 800	<p>Continued From page 10</p> <p>Additionally, this door was inappropriately labeled as an exit route on the floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During an interview on March 19, 2024, at 2:00 p.m., LALD-C verified the door leading into the garage had been designated incorrectly as an exit.</p> <p>3. A thumbturn deadbolt lock was installed 51 inches above the floor on the front door of the facility. Door latching hardware is required to be located not higher than 48" from the floor. Improper installation of door hardware could delay exiting in the event of an emergency. During an interview on March 19, 2024, at 2:00 p.m., LALD-C verified the door locking installation.</p> <p>4. The egress window was difficult to open in the occupied resident basement bedroom. Egress windows that are not maintained in a state of good repair and operation could delay exiting in the event of an emergency. During an interview on March 19, 2024, at 2:00 p.m., LALD-C verified this window required repair.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for 	0 810		

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NAME OF PROVIDER OR SUPPLIER RIVER OF LIFE RESIDENTIAL LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BATTLE CREEK ROAD SAINT PAUL, MN 55119
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0 810	<p>Continued From page 11</p> <p>residents; and</p> <p>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training. 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 potential to affect a large portion or all of</p>	0 810		
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0 810	<p>Continued From page 12</p> <p>the residents). The findings include: On March 18, 2024, and March 19, 2024, the licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN The FSEP included a 9.06 fire policy dated August 1, 2021. This policy was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout and environmental risks. The policy inappropriately referenced smoke compartment doors, fire sprinklers, and doors on magnetic holders. The FSEP included standard resident evacuation procedures but failed to provide employee actions that included individualized unique needs of the residents. The FSEP referenced wheelchairs, sled use, and blanket drags under the evacuation section, but procedures were not included for using these methods.</p> <p>During an interview with survey staff on March 19, 2024, at 2:00 p.m., LALD-C verified the FSEP required revision.</p> <p>TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. During an interview with survey staff on March 19, 2024, at 2:00 p.m., LALD-C verified records were not available to support FSEP training had been completed. LALD-C stated these training records were saved in RTasks and they would try to access this documentation and email it to survey staff. As of March 22, 2024, these training records were not provided.</p>	0 810		

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 830 SS=F	<p>144G.45 Subd. 3 Local laws apply</p> <p>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for a facility remodeling project. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>On March 19, 2024, at 10:00 a.m., survey staff toured the home with licensed assisted living director (LALD)-C. During the facility tour, survey staff observed the basement office was being remodeled. Interior wall surfaces had been removed and several ceiling panels were missing. During the facility tour interview, on March 19, 2024, LALD-C verified the remodeling project and stated this office was only used by staff and residents did not have access to this space. After</p>	0 830		

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0 830	<p>Continued From page 14</p> <p>the facility tour, the licensee provided a copy of a building permit dated October 9, 2023, from the City of St Paul for the project.</p> <p>During an interview with survey staff on March 19, 2024, at 2:00 p.m., LALD-C verified the facility was currently completing a remodeling project and a plan review application had not been submitted to the Minnesota Department of Health Engineering Services.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 830		
01290 SS=D	<p>144G.60 Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification (HFID) number as required for one</p>	01290		

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01290	<p>Continued From page 15</p> <p>of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B started employment on December 6, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.</p> <p>ULP-B's record included a background study dated October 10, 2011. ULP-B's employee record lacked evidence the licensee submitted a background study for ULP-B under the current license and affiliated to the current HFID number.</p> <p>During an interview on March 20, 2024, at approximately 12:00 p.m., licensed assisted living director (LALD)-C stated ULP-B's employee record lacked evidence the licensee submitted a background study for ULP-B under the current license and affiliated to the current HFID number.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
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01640	Continued From page 16	01640		
01640 SS=F	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and/or representative to document agreement on the services to be provided for two of two residents (R1, R2).</p> <p>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</p>	01640		

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01640	<p>Continued From page 17</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 R1 was admitted to the licensee on April 10, 2016.</p> <p>R1's unsigned Service Plan with effective date March 19, 2024, after survey was initiated, indicated R1 was receiving services to include activity assistance, bathing assistance, shower, bedmaking, linen change, laundry, housekeeping, dressing, toileting, incontinence care, mobility assistance, positioning, compression stocking, medication administration, and blood glucose.</p> <p>R1's service plan lacked a signature or other authentication by the resident and/or responsible party documenting agreement on the services to be provided.</p> <p>R2 R2 was admitted to the licensee on June 10, 2014.</p> <p>R2's Addendum to Contract with effective date March 20, 2024, was signed March 20, 2024, after survey was initiated, indicated R2 was receiving services to include bathing assistance, bedmaking, housekeeping, laundry, record blood pressure once a week, and medication administration.</p> <p>During an interview on March 20, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A acknowledged R1's service plan was missing</p>	01640		
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01640	<p>Continued From page 18</p> <p>signatures and R2's service plan was signed March 20, 2024, after survey was initiated. LALD-C further acknowledged R2's service plan with effective date March 20, 2024, after survey was initiated.</p> <p>The licensee's undated Service Plan policy indicated "The service plan and any revisions shall include a signature or other authentication by [License] and by the resident, or resident's representative, documenting agreement on the services to be provided."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) day</p>	01640		
01940 SS=D	<p>144G.72 Subd. 3 Individualized treatment or therapy managemen</p> <p>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:</p> <p>(1) a statement of the type of services that will be provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or</p>	01940		

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01940	<p>Continued From page 19</p> <p>appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of three residents (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's Service Plan with effective date March 19, 2024, indicated R1 was receiving services of blood sugar monitoring and compression stockings.</p> <p>R1's record lacked a treatment and therapy management plan to include: -documentation of specific resident instructions</p>	01940		
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01940	<p>Continued From page 20</p> <p>relating to the treatment or therapy administration; and</p> <ul style="list-style-type: none"> -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises 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. The treatment or therapy management record must be current and updated when there are any changes. <p>During an interview on March 20, 2024, at approximately 1:30 p.m., registered nurse (RN)-A verified a treatment management plan with the required content had not been developed for R1.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
02310 SS=D	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and</p>	02310		

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02310	<p>Continued From page 21</p> <p>services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards with bed rails for one of one resident (R2).</p> <p>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).</p> <p>The findings include:</p> <p>On March 18, 2024, at 11:30 a.m., during the initial tour of the facility, R2 was observed sitting in a hospital bed with a bed rail. R2 stated he used the bedrail to get in and out of bed.</p> <p>R2's Service Plan with effective date March 20, 2024, indicated R2 was receiving services to include bathing assistance, bedmaking, housekeeping, laundry, record blood pressure once a week, and medication administration.</p> <p>R2's Clinical Update Assessment dated March 13, 2024, indicated "mechanical bed with rails" in place for R2. R2's assessment lacked specific measurements of the zones of entrapment.</p> <p>During an interview on March 20, 2024, at approximately 2:30 p.m., registered nurse (RN)-A stated an assessment which included measurements of the zones was expected to be completed for R2's bed rails. RN-A stated it appeared the assessment did not include measurements of zones and the assessment was</p>	02310		
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02310	<p>Continued From page 22</p> <p>not thorough.</p> <p>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.</p> <p>The licensee's Side Rail policy, undated, indicated "The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	02310		
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Type: Full
Date: 03/18/24
Time: 12:00:27
Report: 8058241069

Food and Beverage Establishment Inspection Report

Page 1

Location:

River Of Life Residential Llc
45 Battle Creek Road
St Paul, MN55119
Ramsey County, 62

Establishment Info:

ID #: 0038422
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514948101
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.

2-100 Supervision

2-102.12AMN

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

TRANSFER FOOD SAFETY CERTIFICATE TO STATE CFPM CERTIFICATE USING PROVIDED APPLICATION (PRINTED ON LOCATION)

Comply By: 03/31/24

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: STRAWBERRY
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BACON RAW
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

RESIDENTIAL FINISHES, COMMERCIAL COOLER, ALL OTHER APPLIANCES ARE RESIDENTIAL

HRD INSPECTOR: SAFIA HASSAN
ESTABLISHMENT REP. GAILANN NEHOTTE

Type: Full
Date: 03/18/24
Time: 12:00:27
Report: 8058241069
River Of Life Residential Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058241069 of 03/18/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us