DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 1, 2023

Licensee
Ranier Roost
3443 Pine Street
Ranier, MN 56668

RE: Project Number(s) SL30242015

Dear Licensee:

On July 25, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 31, 2023, 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,

Jessica Chenze

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Electronically Delivered

June 16, 2023

Licensee
Ranier Roost
3443 Pine Street
Ranier, MN 56668

RE: Project Number(s) SL30242015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 and enforcement actions 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, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30242015 On May 30, 2023, through June 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 active residents receiving services under the Assisted Living license.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 1 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 500	Continued From page 2 (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) 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; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 500	Continued From page 3 implemented current policies and procedures, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 30, 2023, at 10:37 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was familiar with current assisted living regulations. The licensee failed to ensure the following policies and procedures were developed, implemented, and kept current: -conducting and handling background studies on employees - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance, and - orientation to and implementation of the assisted living bill of rights. On June 1, 2023, at approximately 10:45 a.m., LALD/CNS-C stated the licensee did not have the policies listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP)-D disinfecting shared equipment in between residents use. In addition, the licensee failed to ensure infection control standards were followed for one of two ULP (ULP-D) with personal cares. 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: SHARED EQUIPMENT	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 510	Continued From page 5 On May 31, 2023, at 6:23 a.m., the surveyor observed ULP-D monitor R7's blood pressure, using an automatic blood pressure machine, and monitor R7's blood oxygen level, using a SpO2 monitor (device that attaches to a finger to monitor and display a reading of how saturated the blood is with oxygen.) The surveyor did not observe ULP-D disinfect the equipment or perform hand hygiene. On May 31, 2023, at 6:29 a.m., the surveyor observed ULP-D monitor R6's blood pressure and blood oxygen level. The surveyor did not observe ULP-D disinfect the equipment or perform hand hygiene. On May 31, 2023, at 6:32 a.m., the surveyor observed ULP-D monitor R4's blood pressure and blood oxygen level. The surveyor did not observe ULP-D disinfect the equipment or perform hand hygiene. Directly following the above observation ULP-D stated she was "new here, still learning" regarding shared equipment disinfecting and hand hygiene. On May 31, 2023, at 6:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the expectation was to disinfect shared equipment after each use using a spray bottle disinfectant. In addition, LALD/CNS-A said at a minimum hand sanitizer should be used by staff. The licensee's Sanitizing Surfaces policy dated May 1, 2022, noted employees were trained on the proper use and handling of all cleaning solutions and chemicals. Use ETOH 70 % alcohol spray bottle for sanitizing blood pressure cuff and O2 saturation finger probe in between each use	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 510	Continued From page 6 (after each resident.) PERSONAL CARES On May 31, 2023, at 6:47 a.m., the surveyor observed ULP-D empty R3's bedside urinal. ULP-D was not wearing gloves. The surveyor did not observe ULP-D perform hand hygiene after emptying R3's urinal. On May 31, 2023, at 10:28 a.m., LALD/CNS-A stated ULP-D and all ULPs should wear gloves when working with urinals and hand's should be washed after working with urinals. The licensee's Hand Washing policy dated May 1, 2022, noted employees would always follow proper hand hygiene. Failure to properly wash hands would result in corrective action and retraining. Hand sanitizers were not used during food preparation or service; -wet hands and exposed arm under warm running water -lather hands with soap -rub hands together vigorously for at least 20 seconds -clean all fingers and thumbs, between fingers, wrists and forearms -removed soil from underneath the fingernails -rinse hands thoroughly under clean, running warm water -dry hands with paper towels or automatic hand dryer, and -use a clean, dry paper towel to turn off faucet and to turn out lights or open door, if needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 550	Continued From page 7	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all current 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	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 550	Continued From page 8 of the residents). The findings include: On May 29, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe a grievance procedure posting to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to MAARC in the common's area of the facility. LALD/CNS-A looked around in a small display stand positioned near the front door for the required information, and said, "nope it is not here". On May 20, 2023, at 11:52 a.m., LALD/CNS-A stated the above information was not posted in the public area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 640	Continued From page 9 to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in the common area to include posting the 911 emergency number and failed to post the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557 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 29, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor observed several cordless telephones in the commons area, however the main entrance and/or common areas lacked the required posting for the 911 emergency number and information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On May 29, 2023, at 11:48 a.m., LALD/CNS-A stated the 911 emergency number and the	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 640	Continued From page 10 contact information for MAARC were not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (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: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 650	Continued From page 11 records contained required content for one of two employees, (unlicensed personnel (ULP)-D.) 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-D was hired on March 23, 2023, to provide direct care services to residents of the facility. On May 31, 2023, at 6:23 a.m., the surveyor observed ULP-D monitor R7's blood pressure, using an automatic blood pressure machine, and monitor R7's blood oxygen level, using a SpO2 monitor (device that attaches to a finger to monitor and display a reading of how saturated the blood is with oxygen.) On May 31, 2023, directly following the above observation ULP-D stated she first did on-line training (Educare), worked with three different unlicensed staff members, and the registered nurse (RN) spent time with her regarding her training. ULP-D's employee record did not include documentation of competency for reading and recording temperature, pulse, and respirations of the resident. On June 1, 2023, at approximately 9:00 a.m., licensed assisted living director/clinical nurse	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 650	Continued From page 12 supervisor (LALD/CNS)-A stated the training was completed however the page was missing from ULP-D's employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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. This MN Requirement is not met as evidenced	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 680	Continued From page 13 by: Based on observation and interview the licensee failed to prominently post a written emergency preparedness plan (EPP). This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 29, 2023, at approximately 11:15 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe signage posted or information regarding the licensee's EPP in the common area of the facility. On May 29, 2023, at 11:45 a.m., LALD/CNS-A stated the facility's EPP plan or notice of the facility's EPP plan was not posted in the commons area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 14 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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This deficient condition had the ability to affect all staff and residents. 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 the residents).	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 15 Findings include: On a facility tour on May 31, 2023, at approximately 11:00 a.m. with facility manager (FM)-F it was observed that smoke alarms were installed in the corridors but the smoke alarm in the corridor near resident room 13 was not interconnected with all smoke alarms in the facility. All smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. This deficient finding was visually verified by FM-F at the time of discovery. 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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 800	Continued From page 16 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 the residents). Findings include: On a facility tour on May 31, 2023, at approximately 11:30 a.m. with facility manager (FM)-F it was observed that the ceiling in the shower room/ bathroom #2 was peeling and flaking off the ceiling above the shower. It was also observed that the cranks were removed from the egress windows in all sleeping rooms. The egress window cranks are required to be maintained as required and approved at the time of construction. The egress windows are required to be operable immediately without the use of tools or special knowledge. A faucet was observed with a hose connected without a vacuum breaker for the protection of the potable water system in the laundry room service sink. Vacuum breaker backflow preventers are required at hose connections to prevent contamination of the potable water system. Exit doors #2, #4, and the main exit door were observed with door locking hardware that requires more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 800	Continued From page 17 The emergency escape window in the resident room across the corridor from resident room 13 in the center of the facility was observed opening into a small exterior courtyard. The courtyard did not have a compliant emergency egress/ rescue path leading to the public way. Please work with the local fire or building code authority for a solution to provide a compliant path of emergency egress/ rescue from the courtyard. It was observed that the rain gutters and downspouts on the exterior of the facility were removed and disconnected. Please repair the rain gutter and downspouts as provided at the time of construction. These deficient conditions were visually verified by FM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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 residents; and (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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 810	Continued From page 18 (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. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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. (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. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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 the residents). Findings include: A record review of available documentation and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 810	Continued From page 19 interview were conducted on May 31, 2023, at approximately 12:45 p.m. of documents provided by the licensed assisted living director, clinical nurse supervisor (LALD/CNS)-A and facility manager (FM)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of twice per year per shift and at least once every other month. All deficiencies were verified by LALD/CNS-A and FM-F during the interview at approximately 12:30 p.m.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 810	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 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:	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 21 On a facility tour on May 31, 2023, at approximately 11:30 a.m. with facility manager (FM)-F, it was observed the marked exterior exit door in the corridor near resident room 5 was provided with locks that required a key code to unlock from the interior in order to exit the facility. During the tour, FM-F indicated the marked exterior exit door locks were not fail-safe so that activation of a fire alarm system, fire sprinkler system, or loss of power releases the door lock for the purpose of exiting in the event of an emergency. Exit doors are required to release to open in one operation unless the door meets the requirements for special locking arrangements of the MN Fire Code. Please work with the local fire or building code authority for a code-compliant solution if you choose to secure exit doors. This deficient condition was verified by FM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (7) days	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 950	Continued From page 22 information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two resident's (R2, R3) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all 12 residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 950	Continued From page 23 R2's Client Service Agreement which included the assisted living contract was signed November 28, 2022. R2's service agreement dated November 28, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist with aid of a lift, laundry, and housekeeping. On May 31, 2023, at 7:21 a.m., the surveyor observed unlicensed personnel (ULP)-C administered R2's morning medication. R2's Client Service Agreement included the sentence, "this person is also my designated representative (list separately if different)" with a checked box. R3 R3's Client Service Agreement which included the assisted living contract was signed December 13, 2022. R3's service agreement dated December 14, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist, laundry, and housekeeping. On May 31, 2023, at 7:35 a.m., the surveyor observed ULP-C prepare and administer R3's morning medication. R3's Client Service Agreement included the	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
0 950	Continued From page 24 sentence, "this person is also my designated representative (list separately if different)" with a checked box. R2 and R3's Assisted Living contracts lacked the following required content: -the right to name a designated representative with the required statutory language; and -a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. On May 31, 2023, at 12:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A said he had "fixed it" (designation representative language) once before and stated the required contents identified above was missing. In addition, LALD/CNS-A stated the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01060	Continued From page 25 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC)	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01060	Continued From page 26 when the resident did not return from the emergency relocation within four days for one of one 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's diagnoses included diabetes, hypertension (HTN-high blood pressure), left hip fracture, atrial fibrillation (irregular, rapid heart rate) and dementia. R3's service agreement dated December 14, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist, laundry and housekeeping. On May 31, 2023, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare and administer R3's morning medication. R3's record included an incident report: date and time of incident May 18, 2023, 7:00 p.m., with follow up notes attached to include: -May 19, 2023, 6:02 a.m., resident on floor complaining of left leg and hip pain, head resting on pillow, staff at residents' side, resident not moved, 911 called immediately. Ambulance on	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01060	Continued From page 27 site at 7:20 p.m., transferred to "RLMC" [local hospital] for evaluation. Registered nurse (RN) notified. -May 19, 2023, RN notified of fall, transferred via EMS (emergency medical services) to "RLMC " where determined hip fracture present. Resident will be transferred to St Mary's Duluth [hospital] for higher level of care. -May 25, 2023, 12:55 p.m., resident returned from Duluth at approximately 9:45 a.m. -May 25, 2023, 1:28 p.m., MAARC online completed, emailing Ombudsman notification. R3's record lacked a written notice that contained, at a minimum: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the OOLTC - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On May 30, 2023, at 1:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he attempted to complete the required form and added the options provided did not apply to R3's situation. LALD/CNS-A stated he was unable to complete the form to	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01060	Continued From page 28 submit it. On May 30, 2023, at 2:23 p.m., LALD/CNS-A said the OOLTC had not been contacted as required, adding he was "on a totally different planet". LALD/CNS-A stated he looked at the form and "thought" R3 did not "relocate." LALD/CNS-A did not choose the "relocate" option to generate the form to be submitted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01420	Continued From page 29 registered nurse (RN) conducted training and competency evaluations of delegated tasks for two of two unlicensed personnel (ULP-C, ULP-D). 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: On May 31, 2023, at approximately 7:40 a.m., the surveyor observed a pressure alarm pad (a sensor that alarms in response to changes in pressure that triggers an alert) in an empty chair in R3's room. The surveyor observed an alarming pressure floor matt in front of R3's bed. ULP-C ULP-C was hired on August 31, 2020, to provide direct care services to residents of the facility. On May 31, 2023, at 7:35 the surveyor observed ULP-C prepare R3's morning medication and take medication to R3's room. The surveyor observed ULP-C move the alarming floor matt and place it under R3's bed. After care was provided to R3, ULP-C returned the alarming floor matt to it's previous location. ULP-D ULP-D was hired on March 23, 2023, to provide direct care services to residents of the facility. On May 31, 2023, at approximately 7:40 a.m., the	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01420	Continued From page 30 surveyor observed ULP-D assist ULP-C to reposition R3 in bed. During this repositioning the surveyor heard an alarm sound. On June 1, 2023, at 9:13 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D did not have "training" or competencies completed for alarms, nor did any of the ULPs working at the facility. LALD/CNS-A stated he had sent out a message to staff dated May 25, 2023, at 2:02 p.m., that noted: -alarms on/ checked/and working on recliner, dinning chair, wheelchair, and bed at all times when he [R3] is in them. The licensee's Client Service Agreement template dated November 22, 2022, noted services would be conducted by unlicensed (delegated and undelegated duties) and licensed personnel; all medical services are supervised by a registered nurse (RN); and unlicensed staff would successfully complete a 30-day skill observation from date of hire. The licensee's Treatment and Therapy policy revised November 1, 2022, noted unlicensed staff may be delegated treatments and therapies post training, and they may include Just in Time training for non-common and unique treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01500	Continued From page 31 complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01500	Continued From page 32 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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 observation, interview and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for one of two employees, (unlicensed personnel, (ULP)-C). 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 was hired on August 31, 2020, to provide direct care services to residents of the facility. On May 31, 2023, at 7:35 a.m., the surveyor	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01500	Continued From page 33 observed ULP-C prepare morning medication for R3's and take them to R3's room for administration. ULP-C's employee record lacked evidence ULP-C successfully completed annual training as required to include: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -reporting maltreatment of vulnerable adults or minors -infection control techniques. On June 1, 2023, at 10:16 a.m., licensed assisted living director/clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-B stated they reviewed ULP-C's training record and said ULP-C had not completed the required annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 34 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 comprehensive reassessment for a change of condition/hospital return for one of two residents (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 30, 2023, at 10:52 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated change of condition assessments were	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 35 completed with hospital returns, adding "if they go to the doctor". R3 began receiving assisted living services on December 14, 2022. R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), left hip fracture, atrial fibrillation (irregular, rapid heart rate) and dementia. R3's service agreement dated December 14, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist, laundry and housekeeping. On May 31, 2023, at 7:35 a.m., the surveyor observed ULP-C prepare R3's morning medication and take the medication to R3's room. R3's record included an incident report: date and time of incident May 18, 2023, 7:00 p.m., with follow up notes attached to include: - May 19, 2023, 6:02 a.m., resident on floor complaining of left leg and hip pain, head resting on pillow, staff at residents' side, resident not moved, 911 called immediately. Ambulance on site at 7:20 p.m., transferred to "RLMC" [local hospital] for evaluation. Registered nurse (RN) notified. -May 19, 2023, RN notified of fall, transferred via EMS (emergency medical services) to "RLMC " where determined hip fracture present. Resident wilt be transferred to St Mary's Duluth [hospital] for higher level of care. -May 25, 2023, 12:55 p.m., resident returned from Duluth at approximately 9:45 a.m.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 36 R3's record indicated the most current assessment for R3 was completed on March 27, 2023. On May 31, 2023, at 1:29 p.m., LALD/CNS-A stated a reassessment should have been completed for R3 on hospital return. LALD/CNS-A added he was "going" to complete an assessment. The licensee's Client Service Agreement, template dated November 22, 2022, noted registered nurse would review, assess, and modify additional needs/service plan on the following schedule, or if any acute changes occur sooner: admit, and by day 14 from admit, with in every 90 days or change of condition with representative/resident notified. Assessments would be based on "in person" and /or resident records available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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. (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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01640	Continued From page 37 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. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three residents (R3) service plans were revised to include provided 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), left hip fracture, atrial fibrillation (irregular, rapid heart rate) and dementia. R3's service agreement dated December 14, 2022, indicated services received included	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01640	Continued From page 38 medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist, laundry and housekeeping. On May 31, 2023, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R3's morning medication and take the medication to R3's room. The surveyor observed ULP-C move an alarming floor matt (alerts caregivers by audible alarm when stepped on/ pressure sensing) positioned alongside R3's hospital bed and place it under R3's bed. The surveyor observed a pressure alarm pad lining a chair in R3's room also. On May 31, 2023, at approximately 7:40 a.m., the surveyor observed ULP-D assist ULP-C to reposition R3 in bed. During R3's repositioning the surveyor heard an alarm sound (pressure bed alarm). R3's record included an incident report: date and time of incident May 18, 2023, 7:00 p.m., with follow up notes attached to include: May 25, 2023, 12:55 p.m., authenticated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A: - "make change to plan of care to include alarms on recliner, wheelchair, dining chair, and bed." On June 1, 2023, at 9:29 a.m., LALD/CNS-A stated R3's service plan was not revised as required to include alarms, adding, "only hospital bed" had been updated. The licensee's Client Service Agreement template dated November 22, 2022, noted additional service needs, upon admission an evaluation for	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01640	Continued From page 39 additional personnel and health care needs would be made ...Registered Nurse would review, assess, and modify your additional needs/service plan on the following schedule, or if any acute changes occur sooner: admit, and by day 14 from admit, with in every 90 days or change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01700	Continued From page 40 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 by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) to determine what medication management services would be provided and included identification and review in all required areas for two of two residents (R2, 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: During the entrance conference on May 30, 2023, at 10:57 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. R2 R2's diagnoses included clavicle fracture (break in the collarbone, one of the main bones in the shoulder), hemiplegia right side (paralysis on right side of body), hypertension (HTN-high blood pressure) and anemia (condition of not having	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01700	Continued From page 41 enough health red blood cells in body). R2's service agreement dated November 28, 2022, indicated services received included medication administration. R2's prescriber orders dated December 16, 2022, included: -amlodipine besylate 2.5 milligrams (mg) daily (high blood pressure) -aspirin 81 mg daily (heart health) -baclofen 10 mg twice daily (muscle stiffness and tightness) -coumadin 2.5 mg, adjust accordingly to anticoagulation clinic orders (blood thinner) -ferosul 325 mg daily (low iron levels) -levetiracetam 500 mg daily (seizures) -lisinopril 2.5 mg daily (high blood pressure/heart failure) -melatonin 5 mg at bedtime (sleep) -Miralax 17 gram, give half daily (bowel health) -multi vitamin daily -senexon-S 8,6-50 mg 2 tablets twice daily (constipation) -sertraline 100 mg daily (depression) -tamsulosin 0.4 mg daily (enlarged prostate). On May 31, 2023, at 7:21 a.m., the surveyor observed ULP-C administer R2's morning medication. R2's Medication Management Services Assessment, dated November 28, 2022, failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. R3 R3's diagnoses included diabetes, hypertension	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01700	Continued From page 42 (HTN-high blood pressure), left hip fracture, atrial fibrillation (irregular, rapid heart-rate) and dementia. R3's service agreement dated December 14, 2022, indicated services received included medication administration. R3's prescriber orders dated May 25, 2023, included: -metformin 500 mg daily (diabetes) -metoprolol 25 mg (heart failure/atrial fibrillation/hypertension) -namenda 10 mg daily (memory) -omeprazole 20 mg daily (heartburn) -risperidone 0.25 mg twice daily (behaviors) -venlafaxine 150 mg daily (depression) -coumadin 2.5 mg- 7.5 mg, adjust accordingly to anticoagulation cline orders (blood thinner). On May 31, 2023, at 7:35 a.m., the surveyor observed ULP-C prepare and administer R3's morning medication. R3's Medication Management Services Assessment, dated December 14, 2022, failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On June 1, 2023, at 9:03 a.m., LALD/CNS-A stated all of the medication assessments were the same and the medication assessment did not address medication diversion. The licensee's Client Service Agreement template dated November 22, 2022, noted a registered nurse would review, assess, and modify resident additional needs/ service plan following a	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01700	Continued From page 43 schedule, or if any acute changes occur sooner. In addition, all medical concerns would be directed to licensed personnel only. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01730	Continued From page 44 (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 ensure the registered nurse (RN) maintained a current individualized medication management plan to include medication reconciliation for one of two 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: During the entrance conference on May 30, 2023, at approximately 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01730	Continued From page 45 licensee's residents. R2's diagnoses included clavicle fracture (break in the collarbone, one of the main bones in the shoulder), hemiplegia right side (paralysis on right side of body), hypertension (HTN-high blood pressure) and anemia (condition of not having enough health red blood cells in body). R2's service agreement dated November 28, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot). On May 31, 2023, at 7:21 a.m., the surveyor observed R2 lying in a bed wearing an arm sling when ULP-C administered R2's morning medication. ULP-C asked R2 what his current pain level was. R2's prescriber orders dated December 16, 2022, included: -amlodipine besylate 2.5 milligrams (mg) daily (high blood pressure) -aspirin 81 mg daily (heart health) -baclofen 10 mg twice daily (muscle stiffness and tightness) -Coumadin 2.5 mg, daily- adjust accordingly to anticoagulation clinic orders (blood thinner) -ferosul 325 mg daily (low iron levels) -levetiracetam 500 mg daily (seizures) -lisinopril 2.5 mg daily (high blood pressure/heart failure) -melatonin 5 mg at bedtime (sleep) -Miralax 17 gram, give half daily (bowel health) -multi vitamin daily, one (1) tablet daily -senexon-S 8, 6-50 mg (Senna S) two (2) tablets twice daily (constipation) -sertraline 100 mg daily (depression) -tamsulosin 0.4 mg daily (enlarged prostate)	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01730	Continued From page 46 -lidocane patch as needed to back, patch to stay in place for 12 hours (pain patch) -acetaminophen 325 mg, take two (2) tablet every 4-6 hours as needed, (mild pain or fever) R2's record included an After Visit Summary (AVS) dated May 12, 2023, noted: reason for visit, fall. Instructions: your medications have changed today, see your updated medication list for details. Read the attached information, clavicle fracture-with sling. The AVS noted: start taking: hydrocodone-acetaminophen 5/325 mg (moderate pain, every six (6) hours as needed, and continue taking: -acetaminophen 325 mg, take two (2) four (4) times a day as needed for mild pain -amlodipine 5 mg, take 2.5 tablet daily -aspirin 81 mg daily -baclofen 10 mg daily -Colace 100 mg twice daily (stool softener) -iron 325 mg daily (supplement) -lactobacillus take one (1) twice daily (may help prevent or treat infectious diarrhea/bowel health) -levetiracetam 500 mg twice daily -lidociane 4% patch apply one (1) patch daily to skin -melatonin 5 mg at bedtime -lisinopril 2.5 mg daily -methylphenidate 5 mg twice daily (attention deficit disorder) -One-A-Day vitacraves (multi vitamin) daily -pantoprozole 40 mg twice daily (stomach aide) -polyethylene glycol (Miralax) 17 gram take half scoop as needed -senna-docusate sodium 8.5-50 mg (Senna-S) 2 tablets daily -sertraline 50 mg	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01730	Continued From page 47 -tamsulosin 0.4 mg daily -warfarin 7.5 mg (Coumadin) daily take as directed by anticoagulation clinic (blood thinner) On May 31, 2023, at approximately 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated he was not working at the facility at the time of R2's return to the facility. R2 said a medication reconciliation should have been completed for R2, adding that was their normal procedure. Licensed practical nurse (LPN)-B produced newly signed orders for R2 after a hospital visit. The licensee's Nursing Assessment template dated December 13, 2021, noted RN (registered nurse) completed individual face-to-face review of orders, service, condition, and medications (side effects, allergies, contraindications, adverse reactions) using documentation/digital information available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01940 SS=D	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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 48 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced 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 one of two residents (R2) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 49 The findings include: During the entrance conference on May 30, 2023, at approximately 11:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to residents. R2's diagnoses included clavicle fracture (break in the collarbone, one of the main bones in the shoulder), hemiplegia right side (paralysis on right side of body), hypertension (HTN-high blood pressure) and anemia (condition of not having enough healthy red blood cells in body). R2's service agreement dated November 28, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist with aid of a lift, laundry, and housekeeping. On May 31, 2023, at 7:21 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medication. R2 was lying in bed and was wearing an arm sling. WOUND CARE R2's provider's order dated May 9, 2023, noted: - apply medical honey to open area on left gluteal fold - cover with a foam dressing. May use border dressing or light amount of tape if necessary - change dressing every three (3) days and as needed (PRN) - refer to home health for wound care.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 50 SLING APPLICATION/SKIN MONITORING R2's provider's order dated May 22, 2023, noted: -ok to remove neck strap from sling when in bed/must be secured when out of bed -skin checks per facility protocol and with right shoulder check top of shoulder daily and monitor for skin breakdown. R2's record did not include evidence of an individualized treatment or therapy management plan which included the following for wound care and sling application/skin monitoring: -a statement of the type of service that would be provided -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that would be delegated to ULP -procedures for notifying the RN or appropriate licensed health professional when a problem arises with treatments or therapy services, and -any resident specific requirements related 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 June 1. 2023, at approximately 9:30 a.m., licensed practical nurse (LPN)-B stated , "staff," "I do it," [check] R2's skin daily. In addition, LPN-B stated home care was doing R2's wound care three days a week. LPN-B added a nurse at the facility would be doing R2's PRN wound care, adding the facility would not call home care for PRN wound care needs. LALD/CNS-A stated he was not working at the facility at the time the orders for R2 were received, adding an unidentified registered nurse (RN) was working at	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 51 the facility at that time. LALD/CNS-A said R2's record had not included an individualized treatment plan for R2 to include the above-mentioned items. The licensee's Treatment and Therapy policy revised November 1, 2022, noted; -orders would describe the procedure or instruction for the treatment or therapy -orders would be communicated to staff, and identified staff trained and then authorized to carry out ordered treatment or therapy -complete proper documentation by staff completing task -updated copy would be in the resident's chart and procedure book/online charting -orders would be communicated to the resident and/or responsible person -monitoring and evaluation would be done by RN, and communicated to the resident/responsible person, and primacy care provider, and -treatment and therapy orders would be current and/ or updated as ordered. In addition, staff would address immediately with nursing if any concern or questions relating to the treatment or therapy prior to carrying out the procedure. Nursing would be notified with any problem or issue that arises with treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01950	Continued From page 52 must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained one of one unlicensed personnel (ULP-C) to demonstrate the ability to follow the procedure to perform the tasks using a body sling for one of one resident (R2). In addition, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01950	Continued From page 53 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included clavicle fracture (break in the collarbone, one of the main bones in the shoulder), hemiplegia right side (paralysis on right side of body), hypertension (HTN-high blood pressure) and anemia (condition of not having enough healthy red blood cells in body). R2's service agreement dated November 28, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist with aid of a lift, laundry, and housekeeping. R2's provider's order dated May 22, 2023, noted: -ok to remove neck strap from sling when in bed/must be secured when out of bed -skin checks per facility protocol and with right shoulder check top of shoulder daily and monitor for skin breakdown. On May 31, 2023, at 7:21 a.m., the surveyor observed ULP-C administer R2's morning medication and inquired if R2 was in any pain. R2 was lying in bed wearing an arm sling. COMPETENCIES ULP-C's record lacked documentation of training and competency evaluations for sling application. SPECIFIC INSTRUCTIONS R2's record did not contain specific instructions	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01950	Continued From page 54 for R2's sling and skin monitoring. On June 1, 2023, at approximately 9:30 a.m., licensed practical nurse (LPN)-B stated, "staff," "I" check R2's skin daily. LPN-B added R2's neck strap is not removed. LPN-B confirmed she did not work weekends. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not working at the facility during the time span the above orders for R2 were received. LALD/CNS-A stated ULP-C's record did not contain training and competencies for R2's sling, adding none of the ULP's records would have training documentation for R2's sling. LALD/CNS-A added R2's record had not contained specific instructions as required. R5 R5's diagnoses included hemiplegia right side (paralysis on right side of body) and cerebrovascular accident (CVA- stroke/when there is loss of blood flow to part of the brain). R5's service plan dated August 9, 2022, included nebulizer/ inhaler treatment/oxygen. R5's provider's orders dated April 7, 2023, included: - oxygen 1-4 liters, to keep saturation (blood oxygen level) greater than 90%, continuous. R5's medication administration record (MAR) dated May 1, 2023, through May 31, 2023, noted: oxygen 1-4 liters per nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) to maintain oxygen level above 90%, see drug leaflet. On May 31, 2023, at 6:50 a.m., the surveyor	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01950	Continued From page 55 observed an oxygen concentrator operating in R5's room, set at 2 liters per minute. R5's nasal cannula was lying on R5's bed. The surveyor observed ULP-D and ULP-C assist R5 onto an electric scooter. ULP-D placed a nasal cannula attached to a small oxygen tank secured to the back of R5's electric scooter under R5's nares and secured it. The surveyor did not observe ULP-C or ULP-D administer oxygen to R5, the oxygen tank valve was not opened to deliver oxygen. R5 then motioned he did not want to wear the nasal cannula, refusing oxygen administration. R5's record did not contain specific instructions for R5's oxygen administration. On May 31, 2023, at 9:28 a.m., licensed practical nurse (LPN)-B stated R5 refuses oxygen often. LALD/CNS-A stated R5's record was missing specific instructions for oxygen regarding refusals and reporting. The licensee's Treatment and Therapy policy revised November 1, 2022, noted; -orders would describe the procedure or instruction for the treatment or therapy -orders would be communicated to staff, and identified staff trained and then authorized to carry out ordered treatment or therapy -complete proper documentation by staff completing task -updated copy would be in the resident's chart and procedure book/online charting -orders would be communicated to the resident and/or responsible person -monitoring and evaluation would be done by RN, and communicated to the resident/responsible person, and primacy care provider, and -treatment and therapy orders would be current	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
01950	Continued From page 56 and/ or updated as ordered. In addition, staff would address immediately with nursing if any concern or questions relating to the treatment or therapy prior to carrying out the procedure. Nursing would be notified with any problem or issue that arises with treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	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 failed to ensure treatments or therapies were administered as prescribed for two of three residents (R2, R5). In addition, the licensee failed to ensure treatment or therapies were administered as directed, for one of two residents (R4). This practice resulted in a level two violation (a	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 57 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: R2 R2's diagnoses included clavicle fracture (break in the collarbone, one of the main bones in the shoulder), hemiplegia right side (paralysis on right side of body), hypertension (HTN-high blood pressure) and anemia (condition of not having enough healthy red blood cells in body). R2's service agreement dated November 28, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist with aid of a lift, laundry, and housekeeping. On May 31, 2023, at 7:21 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medication. R2 was lying in bed wearing an arm sling. WOUND CARE DOCUMENTATION R2's provider's order dated May 9, 2023, noted: - apply medical honey to open area on left gluteal fold - cover with a foam dressing. May use border dressing or light amount of tape if necessary	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 58 - change dressing every three (3) days and as needed (PRN), and - refer to home health for wound care. On June 1, 2023, at approximately 9:20 a.m., licensed practical nurse (LPN)-B stated home care would not be called if R2's dressing required PRN changes, adding a nurse at the facility would provide the service, not a ULP. R2's record did not include evidence staff was completing PRN dressing changes. On June 1, 2023, at approximately 9:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2's record should contain documentation of PRN wound changes in the medication administration record/treatment administration record (MAR/TAR). LALD/CNS-A said there was no documentation PRN wound changes were being done. SKIN CHECK DOCUMENTATION R2's provider's order dated May 22, 2023, noted: -ok to remove neck strap from sling when in bed/must be secured when out of bed -skin checks per facility protocol and with right shoulder check top of shoulder daily and monitor for skin breakdown. On June 1, 2023, at approximately 9:30 a.m., LPN-B stated, "staff," "I do it," [check] R2's skin daily. R2's record did not include evidence staff were completing skin checks daily to monitor for skin breakdown. On June 1, 2023, at approximately 9:30 a.m.,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 59 LALD/CNS-A stated R2's record did not contain any documentation that skin checks were being completed daily as ordered. OXYGEN DOCUMENTATION R5 R5's diagnoses included hemiplegia right side (paralysis on right side of body) and cerebrovascular accident (CVA- stroke/when there is loss of blood flow to part of the brain.) R5's service plan dated August 9, 2022, included nebulizer/ inhaler treatment/oxygen. R5's provider's orders dated April 7, 2023, included oxygen 1-4 liters to keep saturation (oxygen level in blood) greater than 90%, continuous. On May 31, 2023, at 6:50 a.m., the surveyor observed an oxygen concentrator operating in R5's room, set at 2 liters per minute. R5's nasal cannula was lying on R5's bed. The surveyor observed ULP-D and ULP-C assist R5 onto an electric scooter. ULP-D placed a nasal cannula attached to a small oxygen tank on the back of R5's electric scooter under R5's nares and secured it. The surveyor did not observe ULP-D turn the oxygen tank valve on. R5 then motioned he did not want to wear the nasal cannula, refusing oxygen administration. Directly following the above observation ULP-D stated she did not turn R5's oxygen tank on because the "knob" that turns the tank on was missing. R5's medication administration record (MAR) dated May 1, 2023, through May 30, 2023, noted: oxygen 1-4 liters per nasal cannula (a lightweight	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 60 tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) to maintain oxygen level above 90%, see drug leaflet. -30 of 30 opportunities there was no documentation for R5's oxygen use or refusal. On May 31, 2023, at 9:28 a.m., LPN-B said R5's oxygen order was for continuous oxygen. LALD/CNS-A stated R5 often refuses to wear oxygen adding staff should be documenting when it occurs. LALD/CNS-A stated R5's record did not contain documentation regarding R5's oxygen use. ACE WRAP APPLICATION (stretchable cloth/ compression bandage) R4 R4's diagnoses included atrial fibrillation (irregular, rapid heart rate), degenerative arthritis (joint pain and stiffness), dementia, edema (swelling) with cellulitis (bacteria entered through crack or break in skin/infection) bilateral lower extremities (both legs). R4's service plan dated February 1, 2023, included Ace Wraps. R4's provider's orders dated April 5, 2023, noted special foot care as ordered by primary care provider. R4's MAR dated May 1, 2023, through May 31, 2023, noted: ACE wrap bilateral lower extremities from ankle to knee. Report open wounds, document condition and changes, notify nursing with concerns/changes: see TX (treatment) binder for procedure. Standard wrapping without special procedures, see drug leaflet.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 61 On May 31, 2023, at approximately 7:30 a.m., the surveyor observed ULP-C check to see if R4's ACE wraps had been applied. The surveyor observed R4's ACE wraps ended just above R4's feet/ ending near ankles. The surveyor did not observe R4's ACE wraps on R4's legs/calves. On May 31, 2023, at approximately 9:25 a.m., LALD/CNS-A stated R4's ACE wraps were applied incorrectly. LALD/CNS-A added he spoke to ULP-D regarding R4's ACE wraps. Per LALD/CNS-A, ULP-D replied, "I wondered about that (ACE application)." LALD/CNS-A stated he did education with ULP-D regarding R4's ACE wraps at that time. The licensee's Treatment and Therapies policy revised November 1, 2022, noted: -orders would describe the procedure or instructions for the treatment therapy -orders would be communicated to staff, and identified staff trained and then authorized to carry out ordered treatment or therapy -complete proper documentation by staff completing task -updated copy would be in resident's chart and procedure book/online charting. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
02320	Continued From page 62 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP-C), observed during medication administration. 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 was hired on August 31, 2020, to provide direct care services to residents of the facility. ULP-C's employe record indicated ULP-C was trained in medication administration on July 26, 2022. On May 31, 2023, at 7:35 the surveyor observed ULP-C prepare R3's morning medication and put them into a medication cup: -metformin 500 mg -Namenda 10 mg -risperidone 0.25 mg -omeprazole 20 mg	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
02320	Continued From page 63 R3's prescriber orders dated May 25, 2023, noted: -metformin 500 mg daily (diabetes) -metoprolol 25 mg daily (heart failure/atrial fibrillation/hypertension) -Namenda 10 mg daily (memory) -omeprazole 20 mg daily (heartburn) -risperidone 0.25 mg twice daily (behaviors) -venlafaxine 150 mg daily (depression) -coumadin 2.5 mg- 7.5 mg daily, adjust accordingly to anticoagulation clinic orders (blood thinner). Directly following the above observation, ULP-C put R3's medication into a medication cup and took the medication cup to R3's room. The surveyor observed ULP-C place the medication cup on a bedside table and leave R3's room. ULP-C returned to R3's room and stated she needed to go get ULP-D to assist. ULP-C commented R3 was "too heavy for me to get up." On May 31, 2023, at 7:54 a.m., ULP-C stated she "normally" does not leave medications unattended, adding "I thought they would be safe." On May 31, 2023, at 8:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A said he was aware ULP-C left R3's medication in R3's room unattended. LALD/CNS-A stated ULP-C went to him to state she was sorry for leaving R3's medications in R3's room. LALD/CNS-A said medications were not to be left unattended. The licensee's Safe Medication Assistance and Administration/Diversion policy revised June 1, 2023, noted staff must review and receive	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
02320	Continued From page 64 instruction of individual medication administration procedure established for each person when assigned responsibility for medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03070 SS=F	144.6502, Subd. 6 Form Requirements (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain consent for electronic monitoring for two of two residents (R5, R3) who had an electronic monitor device in place. 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:	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
03070	Continued From page 65 R5 R5's diagnoses included hemiplegia right side (paralysis on right side of body) and cerebrovascular accident (CVA- stroke/when there is loss of blood flow to part of the brain.) R5's service plan dated August 9, 2022, included medication administration, nebulizer/ inhaler treatment/oxygen, use of a motorized scooter, housing, and laundry services. On May 31, 2023, at 6:50 a.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-C assist R5 into an electric scooter. The surveyor observed a small electronic monitoring device in R5's room. R3 R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), left hip fracture, atrial fibrillation (irregular, rapid heart rate) and dementia. R3's service agreement dated December 14, 2022, indicated services received included medication administration, with INR (blood test indicating how long it takes for blood to clot), shower assist, bathroom assist, dressing/grooming/oral care, positioning/ transferring assist, laundry, and housekeeping. On May 31, 2023, at 7:35 a.m., the surveyor observed ULP-C prepare R3's morning medication and take medication to R3's room. The surveyor observed a small electronic monitoring device directed at R3's bed. The surveyor observed ULP-C turn the monitoring device away from R3's bed when R3 was repositioned with assistance from ULP-D. ULP-C later returned the monitoring device to it's	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
03070	Continued From page 66 previous location, positioned in the direction of R3's bed. On May 31, 2023, at approximately 7:20 a.m., ULP-C stated there were "cameras" in R5 and R3's rooms, adding they (residents) were "higher fall risks". On May 31, 2023, at 8:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there were two cameras in the living rooms (common areas) and one near charting room/supply room, and isolated resident rooms. On May 31, 2023, at 10:54 a.m., LALD/CNS-A stated there were no written forms for resident monitoring, adding families wanted "them" (cameras) in R5 and R3's rooms. LALD/CNS-A said they were "baby monitors" which did not record. LALD/CNS-A added the "screens" could be taken here and there and they (cameras) were not "running." LALD/CNS-A stated the monitors could capture visual and audio when on. LALD/CNS-A stated the cameras were added during COVID. LALD/CNS-A added he had a policy written but had not completed the "next steps". On May 31, 2023, at 11:25 a.m., ULP-C stated she turned the camera away from R3 since the monitor was in the kitchen, "so people in there did not watch when cares were completed". The surveyor observed the monitor in the kitchen with ULP-C. The monitor was in the off position. ULP-C turned the monitor on and demonstrated how the monitor feed could be changed from one to another camera. The licensee's Electronic Monitoring in Certain	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
03070	Continued From page 67 Facilities policy revised May 24, 2023, noted a resident must consent to electronic monitoring in the resident's room or private living unit in writing on a notifications and consent form. If the resident has not affirmatively objected to electronic monitoring and the resident's medication professional determines that the resident currently lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the resident representative my consent on behalf of the resident. For purposes of this subdivision, a resident affirmatively objects when the resident orally, visually, or through the use of auxiliary aids or services declines electronic monitoring. The resident's response must be documented on the notification and consent form; -(b) prior to a resident representative when consenting on behalf of a resident, the resident must be asked if the resident wants electronic monitoring go be conducted. The resident representative must explain to the resident -(1) the type of electronic monitoring device to be used -(2) the standard conditions that may be placed on the electronic monitoring devices's use, including those listed in subdivision 6 -(3) with whom the recording may be shared under subdivision 10 or 11 -(4) the resident's ability to decline all recording -(c) a resident, or resident representative when consenting on behalf of the resident, may consent to electronic monitoring with any conditions of the resident or resident representative's choosing, including the list of standard conditions provided in subdivision 6. A resident, or resident representative when consenting on behalf of the resident, may request that the electronic monitoring device by turned off or the usual or audio recording component of the electronic	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30242	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANIER ROOST	3443 PINE STREET RANIER, MN 56668

(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
03070	Continued From page 68 monitoring device by blocked at any time. Upon receipt of any completed notification and consent form, the facility must place the original form in the resident's file or file the original form with the resident's housing with services contract. The facility must provide a copy to the resident and the resident's roommate, if applicable. Form requirement: (1) the resident's signed consent to electronic monitoring or the signature of the resident representative, if applicable. If a person other than the resident signs the consent form, the form must document the following: -the date the resident was asked if the resident wanted electronic monitoring to be conducted -who was present when the resident was asked -an acknowledgment that the resident did not affirmatively object and the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03070		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/30/23*
Time: 14:13:17
Report: 1019231048

Food and Beverage Establishment Inspection Report

Location:
Ranier Roost
3443 Pine Street
Ranier, MN56668
Koochiching County, 36

Establishment Info:
ID #: 0038694
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182865633
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.

3-800 Highly Susceptible Populations

3-801.11C ***** Priority 1 *****

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

OBSERVED: FACILITY HAD UNPASTEURIZED EGGS IN THE FRIDGE WHEN QUESTIONED, COOK STATED SHE USED THEM FOR OVER EASY, AND SUNNY SIDE UP EGGS.
CORRECTION: DISCONTINUE PREPARING ANY UNDERCOOKED EGG DISHES UNTIL PASTEURIZED EGGS CAN BE USED.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

OBSERVED FACILITY HAD QUAT. AMMONIA IN A SPRAY BOTTLE INSIDE THE KITCHEN WITH NO WAY TO TEST THE CONCENTRATION OF THE SOLUTION.
CORRECTION: OBTAIN QUAT. AMMONIA TEST STRIPS FOR SAID SANITIZING SOLUTION.

Comply By: 06/09/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

OBSERVED A WET WIPING CLOTH LEFT ON THE COUNTER
CORRECTION: ALWAYS STORE WET WIPING CLOTHS IN A SANI BUCKET WITH AN APPROVED SANITIZING SOLUTION.

Type: Full
Date: *05/30/23*
Time: 14:13:17
Report: 1019231048
Ranier Roost

Food and Beverage Establishment Inspection Report

Comply By: 06/09/23

Surface and Equipment Sanitizers

Hot Water: = at 165 F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 F Degrees Fahrenheit - Location: FRIDGE - KITCHEN
Violation Issued: No

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

DISCUSSION:
SERVING UNDER COOKED TCS ITEMS TO A HIGH RISK POPULATION,
CHEMICAL SANITIZER TEST STRIP REQUIREMENTS,

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

I acknowledge receipt of the inspection report number 1019231048 of 05/30/23.

Certified Food Protection Manager LINDA J. SALO

Certification Number: FM 94520 Expires: 06/15/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
LINDA J. SALO
COOK

Signed: _____
Jared Morrill
Sanitarian
Bemidji
218 308-2128