Electronically Delivered

October 22, 2026

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

RE: Project Number(s) SL31368016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $1,000.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 2040 - 144g.81 Subdivision 1 - Fire Protection And Physical Environment - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL31368016-0 On September 28, 2026, through October 1, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 95 resident(s); 95 receiving services under the Assisted Living Facility Dementia Care license. 2310: An immediate correction order was issued on October 1, 2026, at a level 3/Isolated (G). The licensee took action on October 1, 2026; however, the scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 340	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3 provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 4 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 29, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 5 review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of seven unlicensed personnel (ULP-E) during medication administration and 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: On September 29, 2026, at 7:18 a.m., the surveyor observed ULP-E set up morning medications for R9. ULP-E donned clean gloves and punched out seven medications from their various bubble packs, and after touching several surfaces including the cart and computer keyboard, ULP-E poured R9's vitamin D and Calcium directly into her gloved hand then to the medication cup. ULP-E then administered the medications to R9. ULP-E failed to maintain proper infection control by touching oral medication with gloves that had touched other likely contaminated surfaces. On September 30, 2026, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated staff know not to touch pills when setting up medications. Instead, when pouring from a bottle, staff are to pour into the bottle cap and then pour into the medication	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 6 cup. The licensee's Procedure for Using Gloves policy dated February 20, 2024, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 7 licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed chest X-ray and physician clearance, following a positive TB blood test for one of one employee (unlicensed personnel (ULP)-I). 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-I's employee record indicated a hire date of February 23, 2026, to provide direct care services to the licensee's residents. ULP-I's employee file included a symptom screening dated February 25, 2026, and a QuantiFERON blood test (a blood test to detect TB) dated February 25. 2026, with a positive result; however, ULP-I's employee record lacked evidence he completed a chest X-ray and follow up physician consultation clearing ULP-I of active TB and ability to work directly with residents of the facility. On September 30, 2026, at 10:30 a.m., licensed assisted living director (LALD)-A stated there was no record found in ULP-I's employee file to indicate he had a follow up chest X-ray and consultation, although she thought he likely did.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 8 She further stated she would follow up with ULP-I to obtain proof of follow up. On September 30, 2026, at 3:00 p.m., LALD-A provided the surveyor with a printed copy of ULP-I's chest X-ray results and confirmation he received a provider consultation on March 18, 2026, regarding his TB status and was clear of active TB infection. LALD-A stated ULP-I contacted the provider's office and had the record sent after the surveyor discovered there was no record. The licensee's TB Prevention and Control Policy dated February 20, 2024, indicated that any employee or volunteer with abnormal TB screening results must receive a follow-up medical evaluation by a physician. Such employees may not have any contact with residents until a physician has determined that they do not have contagious TB. The employee must provide copies of the medical reports, chest radiograph results or verification of completed treatment to the agency to keep in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 9 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=C	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.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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) staff actions to be taken in the event of a fire	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 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. (c) Staff 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 staff 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 observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twnety One (21) days.	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must 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;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 13 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 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 interview and record review, the licensee failed to ensure annual training included	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 14 all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C began providing direct care services on November 12, 2016. ULP-C's employee record included a Relias (the licensee's online training system) transcript printed September 29, 2026. The record indicated the last date of training for person centered planning and service delivery and how they apply to direct support services provided by the staff person was June 8, 2024. ULP-K ULP-K began providing direct care services on August 4, 2021. ULP-K's employee record included a Relias training transcript printed September 30, 2026, and indicated the last date of training for person centered planning and service deliver and how they apply to direct support services provided by the staff person was June 19, 2024. The licensee did not ensure all required annual	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 15 training topics were completed as required. On September 30, 2026, at 12:40 p.m., licensed assisted living director (LALD)-A stated from what she could tell, the person-centered training was not assigned to ULP-C and ULP-K, nor to any other ULP since 2024, and would discuss this "miss" with human resources to ensure they are aware of the required training to be completed annually. The licensee's Assisted Living with Memory Care Annual Training policy dated January 31, 2024, indicated all assisted living employees will complete annual education on the following topics: -principles of person-centered planning and service delivery 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 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 16 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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 interview and record review, the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 17 licensee failed to ensure the registered nurse (RN) completed clear assessments of a heel wound and failed to complete a comprehensive assessment for a change in condition for one of one resident (R22). Additionally, the RN failed to complete a comprehensive assessment not to exceed 90 days for one of four residents (R9). 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: R22 R22 was admitted on March 30, 2026, with diagnoses including adjustment disorder with anxiety, type 2 diabetes, and pressure ulcer of left heel. R22's Service Plan dated September 5, 2026, indicated he received services including medication management/administration, blood sugar monitoring, as needed wound care, and safety checks. On September 30, 2026, at 12:40 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed a home care licensed practical nurse (LPN) complete wound care and a dressing change to R22's left heel. CNS-B stated the home care agency nurse completed wound care and dressing changes on Mondays, Wednesdays, and Fridays and the licensee's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 18 unlicensed personnel (ULP) completed it on Tuesday, Thursday, Saturday, and Sunday. CNS-B further stated R22's left heel wound was present at the time of his admission to the facility but had healed a few weeks later. CNS-B stated the left heel wound had reopened in August and had required wound care, which at that time was completed by an ambulance service, and then on an as needed (PRN) basis by the facility staff. Starting September 21, 2026, R22's wound care was then managed by both a home care agency and the facility staff. CNS-B stated R22's wound was assessed weekly by an RN. R22's progress notes indicated: - April 6, 2026, indicated wound care orders will be managed by [home health agency name] and nursing will have weekly progress notes. Resident is going to wound care on his own at this time per his request but he accepted help for home health. - April 15, 2026, indicated resident was needed by [home health agency name] for wound care - May 1, 2026, indicated spoke to [home health agency name] and resident will be discharged from their services today per his request. - May 18, 2026, indicated resident will be seen by wound care [clinic] on May 20, 2026, at 11:00 a.m. per his own request. They will follow up if they get orders to start wound are again. - August 3, 2026, indicated "Skin integrity-left heal [sic]- resident needs an appointment with would [sic] care. His left heal [sic] old wound is unstageable and has mild pain." - August 17, 2026, indicated "Resident has an open area on his left heel measuring 4 centimeters (cm) by 3.5 cm. See wound pictures. Advised for patient to make an appointment (appt)." - August 21, 2026, indicated the nurse called the clinic and schedule resident an appointment for	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 19 August 24, 2026, for further evaluation of the heel wound. - September 4, 2026, indicated R22 would be receiving wound care services by an ambulance service. - September 15, 2026, resident information was faxed to [home care agency name] for review to take over wound care. Resident continues to refuse to purchase wound care supplies due to costs. - September 29, 2026, indicated "Pressure injury wound care was completed by nursing after resident's shower. No drainage or signs of infection, or other complications noted. Wound bed measures approximately 2 cm x l cm. Wound care was completed today with Vashe wound cleanser and Medi Honey as ordered. Wound was covered with a non-adhesive Telfa and then secured with roll gauze and tape provided by resident. Patient tolerated wound care." R22's record included a signed prescriber's order dated April 23, 2026, indicated R22's wound care had been discontinued. R22's prescriber's signed order dated September 14, 2026, indicated R22 had one wound on the heel as a pressure ulcer that was a stage 3 wound (a full-thickness ulcer where the skin is completely lost and the wound extends into the fatty (subcutaneous) tissue, forming a crater-like opening with visible fat but no exposed muscle or bone).The wound measurements were 2.6 cm long, 3.5 cm wide and 0.1 cm deep. The wound required a primary contact layer dressing including Medi honey followed by spandage to be changed daily. R22's record included comprehensive	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 20 assessments indicating: - March 27, 2026, preadmission Health and Service Evaluation-Minnesota Results (comprehensive RN assessment) - April 3, 2026, admission Health and Service Evaluation-Minnesota Results (comprehensive RN assessment) - April 17, 2026, admission Health and Service Evaluation-Minnesota Results (comprehensive RN assessment) - May 1, 2026, 14-day Health and Service Evaluation-Minnesota Results (comprehensive RN assessment) - July 29, 2026, 90-day Health and Service Evaluation-Minnesota Results (comprehensive RN assessment) R22's comprehensive RN assessments listed above all indicated the same statements/responses: - Resident has skin condition-Yes - If the resident has a skin condition, select skin condition that apply-decubitus wound - Resident has orders for skin care-Yes - If resident has orders for skin care, select assistance needed-assistance needed with skin care that requires nurse delegation (describe specific cares, skin care needed, individualized interventions and instructions)-no information was provided - Resident needs wound care-Yes The licensee's RN failed to clearly provide details of R22's heel wound such as location, size, or progression (either healing or worsening) within each assessment. The licensee's RN failed to clearly indicate R22's wound status in the comprehensive RN assessments since his admission and failed to complete a comprehensive RN assessment for a	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 21 change in condition when R22's wound progressed in August 2026, requiring wound care intervention. On October 1, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated R22's assessments "were not refined to include details" of the heel wound and the RN had not recognized the need to complete an assessment for a change in condition with the return of R22's heel wound in August, as it was believed to be a "chronic wound". R9 R9 was admitted on October 9, 2024, with diagnoses including cerebellar stroke syndrome and type 2 diabetes. R9's Service Plan dated August 19, 2026, included the services of medication management/administration, blood sugar monitoring, verbal cues with dressing, bathing, transfers, and safety checks, On September 29, 2026, at 7:18 a.m. the surveyor observed unlicensed personnel (ULP)-E set up and administer eight oral medications and one insulin injection. R9's record included comprehensive RN assessments dated: - January 21, 2026-90-day assessment - April 22, 2026- 90-day assessment - August 5, 2026- admission assessment (admitted from assisted living to memory care) - August 19, 2026- 14-day assessment (following move to memory care) R9's assessment dated August 5, 2026, was completed 105 days from the previous	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 22 assessment (15 days late), thus exceeding 90 days. On October 1, 2026, at 5:00 p.m., CNS-B stated R9's assessment was completed late as R9 moved from the assisted living area to the memory care area and she wanted to wait for that move to occur since it would require an assessment for a change in condition. The licensee's Initial and On-Going Nursing Assessments of Residents policy dated February 20, 2024, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. The RN will reassess each resident on an on-going basis. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. The RN will reassess the resident if the resident has a change in condition. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 23 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan accurately depicted the current services for two of four residents (R4, R22). 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:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 24 R4 R4 was admitted to assisted living services on November 28, 2025, with diagnoses including cerebral infarction (stroke), hypertension, and prostate cancer. R4's Service Plan dated December 19, 2025, indicated R4 received services including assistance with dressing, bathing, grooming, medication management/administration, urinary catheter care and assistance with range of motion (ROM) done daily by nursing. On September 29, 2026, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-I assisted R4 transfer from his recliner to his wheelchair and ULP-H emptied R4's urinary catheter bag. R4's Monthly Task Log (used for task documentation) dated September 2026, indicated he received the following services: - extensive assistance with grooming/personal hygiene - extensive assistance with toileting - enabling device for transfers - extensive assistance with dressing - daily trash removal - safety check daily - showering Tuesdays and Fridays On September 30, 2026, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated R4's ROM exercises were only temporary, and the service plan should have been updated to not include the ROM exercises. The licensee failed to update R4's service plan to reflect R4's ROM/exercises by the licensee were	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 25 no longer a service he received. R22 R22 was admitted on March 30, 2026, with diagnoses including adjustment disorder with anxiety, type 2 diabetes, and pressure ulcer of left heel. R22's Service Plan dated September 5, 2026, indicated he received services including medication management/administration, blood sugar monitoring, as needed wound care, and safety checks. On September 30, 2026, at 12:40 p.m., the surveyor and CNS-B observed a home care licensed practical nurse (LPN) complete wound care and a dressing change to R22's left heel. CNS-B stated the home care agency nurse completed wound care and dressing changes on Mondays, Wednesdays, and Fridays and the licensee's ULP completed it on Tuesday, Thursday, Saturday, and Sunday. CNS-B further stated R22's left heel wound was present at the time of his admission to the facility but had healed a few weeks later. CNS-B stated the left heel wound had reopened in August and had required wound care which initially was completed by an ambulance service and then on an as needed (PRN) basis by the facility staff. Starting September 21, 2026, R22's wound care was then managed daily by both a home care agency and the facility staff. R22's signed prescriber's orders dated September 14, 2026, indicated a stage 3 pressure ulcer on the heel. Wound requires a primary contact layer, the dressing for the primary contact layer is Medi Honey followed by spandage. The frequency of change is once daily.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 26 R22's progress note dated: - September 15, 2026, resident information was faxed to [home care agency name] for review to take over wound care. resident continues to refuse to purchase wound care supplies due to costs. - September 29, 2026, indicated "Pressure injury wound care was completed by nursing after resident's shower. No drainage or signs of infection, or other complications noted. Wound bed measures approximately 2 centimeters (cm) x I cm. Wound care was completed today with Vashe wound cleanser and Medi Honey as ordered. Wound was covered with a non-adhesive Telfa and then secured with roll gauze and tape provided by resident. Patient tolerated wound care." R22's medication administration record (MAR) dated September 2026, included left heel wound care starting September 11, 2026, with instructions indicating: 1. Clean wound with vashe wound cleaner 2. Allow gauze to let sit for 10 minutes 3. Pat dry 4. Apply medi-honey to wound base thickness of a dime 5. cover with thick layer of soft gauze like Telfa (non-adhesive) 6. Secure with roll gauze and tape. 7. change daily The licensee failed to update R22's Service Plan to change R22's service of wound care from as needed by the facility ULP to four times each week by the facility ULP. On October 1, 2026, at 4:30 p.m., CNS-B stated R22's Service Plan was not accurate, and she	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 27 was not aware it had not been updated to accurately reflect the current service/frequency of wound care. The licensee's undated, Contents of Service Plans policy indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans are reviewed and revised as needed based upon on-going resident assessment. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 28 registered nurse (RN) assessed R16's ability to self-administer medications. 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 September 28, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents at the facility. R16 began receiving services under the licensee's assisted living with dementia care license on June 8, 2026, with diagnoses including mild cognitive impairment, spinal stenosis, and chronic pain syndrome. R16's Service Plan dated June 26, 2026, indicated he received services including medication management/administration. On September 29, 2026, at 10:10 a.m., the surveyor observed unlicensed personnel (ULP)-F set up a nebulizer and turned it on, handing the nebulizer with tubing to R16 and directing it to his face. ULP-F started the nebulizer machine and stated she would return in about 10 minutes. R16 asked what he was supposed to do with it because the day before, no one returned to check on him or turn of the machine for about an hour.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 29 ULP-F instructed R16 to keep it in place until she returned. R16's signed prescriber's orders dated September 2, 2026, included an order for ipratropium-albuterol 0.5-2.5 milligram (mg)/3 milliliter (ml) nebulizer solution. Inhale 3 ml by nebulization every morning. May have three additional nebulizer treatments daily as needed for management of shortness of breath and wheezing. R16's comprehensive RN assessment dated September 10, 2026, included R16's medication assessment and plan which indicated R16 could not take medication without assistance. The RN did not assess R16's ability to self-administer a nebulizer. The ULP did not ensure R16 was monitored to safely self-administer his nebulizer. On September 30, 2026, at 2:55 p.m., CNS-B stated R16's nebulizer had just started recently. R16 had not been assessed by the RN for self-administration and the ULP should not have left R16 alone to finish the nebulizer. The licensee's Development of the individualized medication management plan and individualized medication record policy dated January 26, 2024, indicated the RN will assess what medication services will be provided and how the services will be provided. Prior to providing medication management services the RN will review all medications the resident is known to be taking. Following the completion of the nursing assessment, including an assessment of the resident's needs for medication management, the RN develops an individualized medication	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 30 management plan for the resident in conjunction with the resident and/or the resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 31 when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for the licensee's two of four residents (R4, R22). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted to assisted living services on	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 32 November 28, 2025, with diagnoses including cerebral infarction (stroke), hypertension, and prostate cancer. R4's Service Plan dated December 19, 2025, indicated R4 received services including medication management/administration. On September 29, 2026, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-I assist R4 transfer from his recliner to his wheelchair and ULP-H emptied R4's urinary catheter bag. ULP-H stated R4 had received his medications earlier in the morning. R4's Medication administration Record (MAR) dated September 2026, included one medication for blood pressure, one blood thinner, one for cholesterol, one for heart rate, one for prostate management, one for muscle spasms, two for constipation, one for acid reflux, one for water retention, one for mild pain, two supplements, one nasal spray, two topical powders, one nebulizer for shortness of breath, and one topical pain medication. R4's medication plan found in R4's comprehensive registered nurse (RN) assessment dated August 6, 2026, included: - resident needs assistance with medication storage - medications stored in a central medication storage location - resident has been instructed on appropriate interventions to prevent diversion R4's medication plan lacked the required content including: - a statement describing the medication management services that will be provided;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 33 - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. R22 R22 was admitted on March 30, 2026, with diagnoses including adjustment disorder with anxiety, type 2 diabetes, and pressure ulcer of left heel. R22's Service Plan dated September 5, 2026, indicated he received services including medication management/administration. On September 30, 2026, at 12:40 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed a home care licensed practical nurse (LPN) complete wound care and a dressing change to R22's left heel. CNS-B stated the licensee managed R22's medications, the ULP administered medications and set up R22's insulin pen and observe R22 self-administer the insulin. R22's MAR dated September 2026, included one medication for cholesterol, one for depression,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 34 one for blood thinning, two for blood pressure, one for sleep, one for heart rate control, one for PTSD (post-traumatic stress disorder), one for prostate, one topical antifungal, one supplement, one for mild pain, two for constipation, and two injectables for diabetes. R22's medication plan found in R22's comprehensive RN assessment dated July 29, 2026, included: - resident has medication orders - resident needs assistance with medication storage-staff administers medications - resident medication storage location-medication is stored in a central medication storage location - resident has been instructed on appropriate interventions for preventing diversion R22's medication plan lacked the required content to include: - documentation of specific resident instructions relating to the administration of medications - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. On September 30, 2026, at 4:10 p.m., CNS-B stated the licensee had a form from the previous	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 35 survey used for that correction, as the electronic medical record (EMR) used did not include the required content for medication plans. CNS-B stated other RNs have helped with comprehensive assessments and had not always used the form to help guide them for the required content and stated they (the licensee's nurses) have missed including the required content in some residents' medication plans. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy dated January 26, 2024, indicated: Following the completion of the nursing assessment, including an assessment of the resident's needs for medication management, the RN develops an individualized medication management plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: a. Identification of the medication management services to be provided by [licensee name]. b. Description of how medications managed by our facility will be stored, based on the residents' needs, risk of diversion, and consistent with the manufacturer's directions. c. Identification of any specific resident instructions regarding medications our facility staff will administer; d. Identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis e. Identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; f. Procedure for staff to notify the licensed nurse there is a problem with any medication management service; g. Any resident specific requirements relating to	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 36 the documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure PRN (as needed) medication had documentation of effectiveness after administration for the one of four residents (R4) This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 37 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: R4 was admitted to assisted living services on November 28, 2025, with diagnoses including cerebral infarction (stroke), hypertension, and prostate cancer. R4's Service Plan dated December 19, 2025, indicated R4 received services including medication management/administration. On September 29, 2026, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-I assist R4 transfer from his recliner to his wheelchair and ULP-H emptied R4's urinary catheter bag. ULP-H stated R4 had received his medications earlier in the morning. R4's Medication administration Record (MAR) dated September 2026, included one medication for blood pressure, one blood thinner, one for cholesterol, one for heart rate, one for prostate management, one for muscle spasms, two for constipation, one for acid reflux, one for water retention, one for mild pain, two supplements, one nasal spray, two topical powders, one nebulizer for shortness of breath, and one topical pain medication. As needed (PRN) medications R4's MAR dated September 2026, included the following PRN medications:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 38 - Baclofen (for muscle spasms) 20 milligrams (mg), give one tablet by mouth as needed one time daily - ipratropium bromide inhalation solution 0.02% solution (for shortness of breath), give 2.5 milliliters (ml) as needed four times daily R4's MAR indicated he received the PRN Baclofen on September 27, 2026, at 5:21 a.m., and ipratropium bromide on September 28, 2026, at 9:00 p.m. R4's record did not include documentation of the effectiveness of the medication administrations. On September 30, 2026, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated the ULP are to follow up with PRN medications within 30 to 60 minutes after a PRN medication is given and the electronic system used provides a pop-up reminder. The licensee's Administration and Documentation of PRN Medications policy dated February 20, 2024, indicated the registered nurse (RN) or licensed practical nurse (LPN) will document in the resident's medication record/MAR the PRN medication name, symptoms for which the PRN medication may be administered, dose, route, frequency, where it is stored, when the supervising nurse needs to be notified and whether staff must check back with the resident following administration to determine whether the PRN was effective, and if so, the length of time after administration when the staff must check with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 39	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments permitting only authorized personnel access. This had the potential to affect the licensee's current secured memory care residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 28, 2026, at 11:15 a.m., clinical nurse supervisor (CNS)-B indicated the licensee provided medication management and medications were securely stored in two locked medication carts in the assisted living area of the facility, and one locked medication cart in the secured memory care unit. On September 29, 2026, at 6:30 a.m., the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 40 surveyor entered the secured memory care unit of the facility and observed the medication cart unlocked with a medication cup containing a resident's medications sitting unsupervised on the medication cart. The surveyor observed unlicensed personnel (ULP)-E leaving a resident's room down the hall from the medication cart. ULP-E left the medication cart unattended for an undetermined amount of time while she tended to a resident in their room. The surveyor observed other residents in the secured memory care area in proximity to the cart. On September 30, 2026, at 2:45 p.m., CNS-B stated the ULP should never leave medications out unsupervised, nor leave the medication cart unattended while unlocked. The licensee's Storage of Medications policy dated February 20, 2024, indicated medications will be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies 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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 41 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 the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of five residents (R22, R24) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 28, 2026, at 11:15 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided treatments. R22 R22 was admitted on March 30, 2026, with diagnoses including adjustment disorder with	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 42 anxiety, type 2 diabetes, and pressure ulcer of left heel. R22's Service Plan dated September 5, 2026, indicated he received services including blood sugar monitoring and wound care (as needed). On September 30, 2026, at 12:40 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed a home care licensed practical nurse (LPN) complete wound care and a dressing change to R22's left heel. CNS-B stated the home care agency nurse completed wound care and dressing changes on Mondays, Wednesdays, and Fridays and the licensee's unlicensed personnel (ULP) completed it on Tuesday, Thursday, Saturday, and Sunday. CNS-B stated the licensee's ULP also assisted R22 with blood sugar monitoring and medication administration. R22's signed prescriber's orders dated July 27, 2026, included an order for blood sugar monitoring four times daily. R22's signed prescriber's orders dated September 14, 2026, indicated the wound dressing requires a primary contact layer. The dressing for the primary contact layer is Medi honey followed by Spandage. The frequency of change is once daily. R22's medication administration record (MAR) dated September 2026, indicated blood sugar check four times per day with special instructions: 8:30 a.m. self-reading by resident-report only at 10:30 a.m., has Libre reader only, no needles required. R22's MAR dated September 2026, also included wound care with instructions. Clean wound with Vashe wound cleaner-allow gauze to	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 43 let it sit for 10 minutes-pat dry-apply Medi-honey to wound base thickness of a dime-cover with a thick layer of soft gauze like Telfa (non-adhesive) and secure with roll gauze and tape. Change daily. R22's record lacked written instructions for R24's blood sugar parameters and concerns with wound care/wound condition (changes in drainage, size, odor, redness) and when to notify nursing. R24 R24 began receiving services from the licensee on June 9, 2025, with diagnoses including Parkinson's disease, dementia and depression. R24's Service Plan dated July 10, 2026, included assistance with dressing including adding the abdominal binder in the morning and removing in the evening. With added instructions, "do not put directly on the skin". R24's signed prescriber's orders dated July 26, 2026, included abdominal binder-apply through the day while awake for management of orthostatic hypotension symptoms (a rapid drop in blood pressure with position changes). On September 29, 2026, at 12:47 p.m., the surveyor observed ULP-E apply a topical pain medication to R24's chest wall. The surveyor observed an abdominal binder in place over R24's shirt around the trunk of her body. ULP-E stated R24 wore the abdominal binder during daytime hours and was removed by staff at bedtime. R24's MAR dated September 2026, indicated abdominal binder-apply throughout the day while	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 44 awake for management of orthostatic hypotension symptoms R24's record lacked written instructions for R24's abdominal binder and when to notify nursing. On October 1, 2026, at 5:00 p.m., CNS-B stated she was not aware of the need for additional written instructions for residents with treatments and directing when the ULP should contact nursing. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated February 20, 2020, indicated the nurse must instruct the ULP regarding the type of information reportable to a nurse regarding assistance or administration of medications, treatment, and therapy including side effects, effectiveness, refused or held medications, medication errors, and provision of treatment and therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=I	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 45 be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 29, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	02040		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 46 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R22) who had a hospital bed with bedrails. This resulted in an immediate correction order on October 1, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 October 20, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were aware of the requirements for bedrail systems (hospital bed or consumer bed rail systems) for assisted living residents and had a system in place for ongoing monitoring of bedrail systems in the facility. R22 was admitted on March 30, 2026, with diagnoses including adjustment disorder with anxiety, type 2 diabetes with neuropathy (nerve pain), obesity and chronic diabetic heel wound.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 47 R22's Service Plan dated September 5, 2026, included the services of medication management/administration, blood sugar monitoring, wound care, and safety checks. On September 30, 2026, at 1:50 p.m., the surveyor and CNS-B observed a home health nurse complete wound care on R22's left heel wound. While in R22's apartment, the surveyor observed a hospital bed with bilateral bedrails in an upright position. On October 1, 2026, at 9:30 a.m., the surveyor reviewed R22's Health and Service Evaluations-Minnesota Results (known as the RN comprehensive assessment) dated April 6, 2026, April 17, 2026, May 1, 2026, and July 29, 2026. The assessment section labeled "Assessment Supportive Devices" indicated the answer "no" to the statement "resident uses side rails or other supportive devices", and "none apply" to the statement "If resident uses siderails or other supportive device check all that apply". R22's record did not include an assessment of his hospital bed rail, nor education on the risks and benefits of bed rail use, as required. On October 1, 2026, at 9:33 a.m., LALD-A indicated the licensee was not aware R22 had a hospital bed with bedrails. On October 1, 2026, at 10:20 a.m., CNS-B stated she was not aware of R22's hospital bed with rails and thought it may have been brought in without her knowledge. At 11:15 a.m., the surveyor and CNS-B met with R22 in his apartment and observed his hospital bed with bilateral bedrails in the upright position. The rails were securely connected to the bed. R22 stated his wife had	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 48 given him the hospital bed in 2016, and he brought it to the facility at the time he moved in. He further stated he used the bed and could not get out of bed without the bed rails. CNS-B further reviewed R22's comprehensive assessments and resident record for any evidence that a registered nurse (RN) completed an assessment or had a discussion of the risks and benefits of bedrails. She stated she could not find anything and would complete it now. On October 1, 2026, at 11:25 a.m., LALD-A stated the facility tracked all residents with bedrail systems monthly, and she found R22's hospital bedrail measurements on the tracking form dated September 2026. The licensee's Assessing the Safety of Side Rails Policy dated May 31, 2024, indicated due to the risk of injury related to the use of physical devices, such devices may only be used after an assessment has been completed to determine the risks and benefits of this use. The resident/family members must be educated regarding the risks and benefits of physical devices. Physical devices must be reviewed for safety and used according to manufacturers' recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 49 the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The residents' preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 50 shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took action on October 1, 2026; however, the scope and level remain at G.	02310		
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 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 follow delegated procedures for medication administration for one of 16 residents (R15) 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 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:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 51 R15 began receiving services under the licensee's assisted living with dementia care license on November 11, 2021. R15's Service Plan dated June 17, 2026, indicated she received medication management/administration. On September 29, 2026, at 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R15's diclofenac topical gel (used for pain). ULP-G squirted an undetermined amount of diclofenac gel on her gloved fingertips and applied to R15's right shoulder per R15's request. ULP-G stated she knew there was a measuring tool to accurately measure the dosing as ordered but did not see the tool. She further stated a nurse told her a "trick" was to measure the dose by length of the fingers. ULP-G then returned to the medication cart and looked in the box holding the diclofenac gel and found the measuring tool. R15's signed prescriber's orders dated August 24, 2026, included diclofenac 1% gel, apply 4 grams (gm) topically four times daily to hands, knees and area of right flank. Do not apply to open wounds. ULP-G did not use the appropriate measuring tool to administer the correct dosage of diclofenac gel. On October 1, 2026, at 4:30 p.m., clinical nurse supervisor (CNS)-B stated the staff know to use the measuring tool to accurately dose diclofenac gel. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31368	A. BUILDING: _____ B. WING _____	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA RIVER BEND	30 SILVER LAKE PLACE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 52 policy dated February 20, 2024, indicated medications, treatment and therapy always need to be administered according to the six rights: a. Person b. Dosage c. Route d. Time e. Medication f. Charting/documentation No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

AVIVA RIVER BEND
30 SILVER LAKE PLACE NW
Rochester, MN 55901
Olmsted County
Parcel:

Phone:

License Info

License: HFID 31368

Risk:
License:
Expires on:
CFPM: Sara Paul
CFPM #: 58663; Exp: 9/29/2028

Inspection Info

Report Number: F1038261158
Inspection Type: Full - Single
Date: 9/29/2026 Time: 10:30:32 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
DRAIN FOR CONDENSATION FROM WALKIN COOLERS IS DAMAGED
Comply By: 10/1/2026 Originally Issued On: 9/29/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.12 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.
COMMENT:
CUTTNG BOARDS ARE SCORED AND DAMAGED
Comply By: 10/29/2026 Originally Issued On: 9/29/2026

! **New Order: 5-200B Plumbing: cross connections**
5-203.14 *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.
COMMENT:
NO BACKFLOW PREVENTION INSTALLED ON THE WATER SYSTEM AT MOP SINK
Comply By: 10/6/2026 Originally Issued On: 9/29/2026

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F1038261158 from 9/29/2026

Sara Paul
Facility Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL31368016	**Date:** 9/29/2026
Facility Name: Aviva River Bend	
Facility Address: 30 Silver Lake Place NW, Rochester, MN 55901	

☒ **TAG IDENTIFICATION: 0340**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. [Minn. Stat. 144G.30 subd.5]

   Comments: The licensee failed to provide record of actions taken to comply with deficiencies noted during the previous survey. During the previous survey the surveyor noted that the licensee failed to provide an adequate safety risk assessment and mitigations of the risks identified. During the survey on September 29, 2026, the licensee did not provide adequate documentation of a safety risk assessment. No facility specific information was provided, and only generic instructions on how to create a safety risk assessment were included in documents provided to the surveyor. The licensee failed to provide evidence of actions taken to correct the deficiency since the last survey.

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved

location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: The memory care wing on the first floor had controlled egress hardware installed on all of the exit doors from the wing. Facility staff were unaware of any capability to unlock the controlled egress doors from an approved location via a remote release. Staff stated that there may be the potential to unlock doors from the front desk computer but were unaware of the procedures to accomplish this and were unable to access any system that would unlock doors during the survey. Facility staff were not trained on the ability to unlock doors remotely or the location and procedures to unlock the controlled egress doors remotely. All controlled egress doors should be readily openable by staff from an approved location in the event of an emergency.

3. Delayed egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center and other approved locations. An attempt to egress shall initiate an irreversible process that shall allow egress in not more than 15 seconds when a physical effort to exit of not more than 15 pounds (67 N) is applied to the egress side door hardware for not more than one second. Initiation of the irreversible process shall activate an audible signal in the vicinity of the door. Once the delay electronics have been deactivated from an approved location, relocking the delay electronics shall be by manual means only. A sign shall be provided on the door and shall be located above and within 12 inches (305 mm) of the door exit hardware. For doors that swing in the direction of egress, the sign shall read: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 [30] SECONDS. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.8.1]

   Comments: Delayed egress hardware was installed on exit doors throughout the first floor of the facility. The delayed egress doors did not have any signage indicating their operation. Facility staff were also unaware of any capability to unlock the delayed egress doors from an approved location via a remote release. Staff stated that there may be the potential to unlock doors from the front desk computer but were unaware of the procedures to accomplish this and were unable to access any system that would unlock doors during the survey. Facility staff were not trained on the ability to unlock doors remotely or the location and procedures to unlock the controlled egress doors remotely. All delayed egress doors should be readily openable by staff from an approved location in the event of an emergency.

4. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The smoke alarm installed in resident room 404 was covered in plastic and failed to respond to when tested by facility staff during the survey. The plastic was removed and the smoke alarm was able to function properly. All smoke alarms should be maintained in proper functioning condition and free of obstruction.

5. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: The fire rating placards on fire doors around the facility were painted over and difficult to read. Fire rated doors should have the appropriate rating placards displayed and those placards should not be obstructed.

6. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The unit door to resident room 411 was propped open with a door stopper and was not properly maintained as self-closing. The unit door did not have automatic closing hardware, and the door should be maintained to close and latch during an emergency without obstruction.

7. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   Comments: Proper clearance was not maintained around the sprinkler heads in resident rooms 415, 411, 318, 203 and the second-floor employee break room. In these locations items were placed directly underneath the sprinkler head which may have obstructed the flow of water and posed a risk of accidentally triggering the sprinkler operation due to possibly putting pressure on the heads. Proper clearance around sprinkler heads should be maintained and stored items should be placed sufficiently far below sprinkler equipment to prevent accidental discharge and ensure proper coverage during an emergency.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

---

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments:

   There were several tiles missing from the drop tile ceiling in the third-floor employee breakroom.

   An exit sign mounted to the ceiling in the hallway of the memory care wing was hanging loose and appeared to be missing screws which had affixed it to the ceiling. The exit sign should be reattached and properly secured to the ceiling and maintained in proper state of repair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

---

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. The FSEP contained general plans for staff actions during evacuation but did not contain specific information relevant to the facility. Facility staff were unaware of procedures for evacuation during a fire during similar emergency and indicated that they were unaware of fire alarm pull stations or similar fire safety devices in the facility. The FSEP should include site-specific staff actions for evacuation and include instruction on the operation of fire safety equipment installed in the facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific resident actions for evacuation during a fire or similar emergency. No resident actions for evacuation were included in the FSEP, and facility staff were unable to provide documentation to the surveyor. The FSEP should include site-specific resident actions for evacuation.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide specific procedures for resident movement or evacuation that included unique resident needs for evacuation. Documents in the FSEP included only general levels of ability for residents, but did not include specific needs for residents. Information should be provided to identify unique resident needs so that staff or fire fighting personnel may properly assist them in an emergency. These procedures should be maintained as accurate and up to date.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

---

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: The licensee failed to provide an accurate and up to date safety risk assessment for the facility. The safety risk assessment provided to the surveyor during survey was a general template that was not specific to the facility and was not filled out. Facility staff were unable to locate or provide a complete and accurate safety risk assessment for the facility or any documentation of mitigations taken to address safety concerns. A safety risk assessment should be completed and maintained to identify safety hazards and mitigations should be implemented and documented to address the hazards identified.