Electronically Delivered

March 11, 2024

Licensee
Hillcrest Suites
1520 East Highway 37
Hibbing, MN 55746

RE: Project Number(s) SL39300015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on February 22, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

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If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39300	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SUITES	1520 EAST HIGHWAY 37 HIBBING, MN 55746

(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: SL39300015 On February 20, 2024, through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 23 residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 20, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 2 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of three employees (clinical nurse supervisor (CNS-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on July 7, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's	0 650		

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0 650	Continued From page 3 employees. On February 20, 2024, during the entrance conference at 9:14 a.m., CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include documentation of all required annual training to include: -the principles of person-centered planning and service delivery and how they apply to direct support services. On February 21, 2024, at 12:22 p.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed CNS's record did not include the above required training. LALD/RN-A added CNS-C taught that class, adding it was "weird" CNS-C's record was missing the requirement. The licensee's Employee Records policy dated July 9, 2023, noted employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable	0 700		

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0 700	Continued From page 4 relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure resident's personal health and medical information was kept private for one of four residents, (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 20, 2024, at 11:08 a.m., the surveyor observed unlicensed personnel (ULP)-B go to a medication cart which was positioned in the main entryway of the facility which flowed into a small common's area/TV area. ULP-B opened the lap top computer placed on top of the medication cart. ULP-B looked at R3's electronic medication record (EMAR.) ULP-B closed the computer screen and went over to a chair located in the TV area and spoke to R3. ULP-B returned to the medication cart and unlocked the cart and opened the computer screen and prepared R3's medication. ULP-B left the medication cart and walked over to a chair in the TV area in the entry/ common's area and ULP-B handed R3	0 700		

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0 700	Continued From page 5 medication. The surveyor did not observe ULP-B close the lap top computer screen when ULP-B left the medication cart and administered medication to R3. ULP-B returned to the medication cart and ULP-B documented R3's medication as given. ULP-B left the computer screen open with resident information visible and pushed the medication cart down the hallway. The surveyor observed an unidentified resident walk past the opened lap top screen. On February 20, 2024, at 11:28 a.m., ULP-B stated the computer screen is left up (opened) until the medication pass was completed. On February 20, 2024, at 12:30 p.m., licensed assisted living director/ registered nurse (LALD/RN)-A stated ULPs (staff) are not to leave the computer screen open, where "anyone" can view it (medical/personal information.) The licensee's Confidentiality policy dated July 12, 2023, noted the licensee takes confidentiality of information very seriously. Personal, financial, medical, or other private information regarding residents or staff should not be disclosed to any other person except: -as may be required by law -to other staff as appropriate or necessary to provide services -to persons authorized in writing by the resident or resident's responsible person to receive the information, including third party payers or -to representatives of the commissioner authorized to survey or investigate any part of the community. It is an employee's responsibility to stop co-workers for other staff from discussing inappropriate resident or staff information in public areas.	0 700		

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0 700	Continued From page 6 The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to have personal, financial, health, and medical information kept private. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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	0 800		

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0 800	Continued From page 7 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 22, 2024, at 11:15 a.m., with maintenance (M)-F and housing director (HD)-H, the surveyor made the following observations of facility hazards and disrepair: The privacy locks were barrel bolt type locks and were difficult and sticky to operate in the men's and women's public restrooms in the main entrance lobby area. Door locks are required to be an approved egress type lock that is easily operated with one motion. During a facility tour on February 22, 2024, at 11:20 a.m., HD-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 8 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 9 The findings include: On February 22, 2024, at 9:45 a.m., housing director (HD)-H, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing written documentation the residents were offered training based on the FSEP at least annually. During an interview on February 22, 2024, at 10:00 a.m., HD-H, stated written documentation was not available indicating residents had been offered training based on the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 10 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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01470	Continued From page 11 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on July 7, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On February 20, 2024, during the entrance conference at 9:14 a.m., CNS-C identified herself as the CNS for the facility. CNS-C's employee record included: -assisted living bill of rights, dated January 10, 2022 -HIPAA (health insurance portability and accountability act,) dated February 19, 2022 -infection control, dated March 21, 2022 -vulnerable adult, dated March 21, 2022	01470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 12 -person-centered care, dated July 7, 2021. CNS-C's employee orientation record did not include: -an overview of the 144G statutes as required -introduction and review of the facility's policies and procedures -handling of emergencies and use of emergency services. -handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On February 22, 2024, at 9:09 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was not aware orientation training needed to be repeated for CNS-C as she had previously been employed by the licensee, previous employment ended in April 2022. LALD/RN-C confirmed CNS-C's had not completed orientation for her July 7, 2022, hire date. The licensee's Orientation & Training policy dated July 12, 2023, noted all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -an overview of the appropriate Assisted Living statutes and rules -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -handling of emergencies and use of emergency services -compliance with and reporting of the	01470		

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01470	Continued From page 13 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -handling of resident's complaints, reporting of complaints, and where to report complaints, including information the Office of Health Facility Complaints -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Service, county-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee would be providing and the facility's category of licensure -the identification of incidents of maltreatment as defined under Minnesota Statues, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 14 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 medication was administered according to the medication administration plan for one of four residents (R3.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses include chronic angle closure glaucoma of right eye (high eye pressure,) major depressive disorder, mood disorder, and generalized anxiety disorder. R3's service plan dated February 1, 2024, indication R3 received medication administration	01760		

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01760	Continued From page 15 five times daily. On February 20, 2024, at 11:08 a.m., the surveyor observed unlicensed personnel (ULP)-B review R3's electronic medication record (EMAR) and unlock the medication cart. ULP-B removed a bottle of pilocarpine eye solution (high eye pressure) 2% for R3 and walk over to a chair in a TV area in the entry/common's area. ULP-B handed the eye solution to R3, and R3 instilled one drop into her right eye. The surveyor observed ULP-B document R3's eye solution as administered. R3's prescriber order dated November 1, 2023, included: -pilocarpine 2% eye drops instill one drop right eye twice daily. R3's EMAR dated February 1, 2024, through February 20, 2024, included: -pilocarpine solution 2% daily, instill one drop in right eye twice a day: 12:00 p.m., 5:00 p.m. R3's Individualized Medication Management Plan dated February 15, 2024, included: -staff trained by the RN (registered nurse) will administer all medications per MD (medical doctor) orders -staff, trained by the RN, will administer all medications documented in the MAR. On February 20, 2024, at 3:32 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-B should have administered R3's eye drop. LALD/RN-A added the nurse had not done an assessment for R3 to self-administer eye drop medication. The licensee's Medication	01760		

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01760	Continued From page 16 Management-Administration & Setup policy dated July 12, 2023, noted assistance with medication administration would be documented on the MAR by entering the ULP's initial under the date and opposite the medication and dose given and include the full signature and title of the person who provided the mediation administration. In addition, the ULP would document any 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 medications were secure and permitted access to only authorized personnel into one of one medication cart. 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	01880		

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01880	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 20, 2024, at 11:08 a.m., the surveyor observed unlicensed personnel (ULP)-B unlock the medication cart that was positioned in the main entryway of the facility which flowed into a small common's area/TV area. ULP-B removed a bottle of pilocarpine eye solution (high eye pressure) 2% for R3. ULP-B left the medication cart and walked across the room to a chair in a TV area in the entry/common's area and ULP-B handed the eye solution to R3, and R3 instilled one drop into her right eye. The surveyor did not observe ULP-B lock the medication cart prior to walking away from the medication cart to administer R3's medication. On February 20, 2024, at 11:15 a.m., the surveyor observed ULP-B leave the unlocked medication cart in the dining area and go across the room and behind a desk, to answer the telephone. The surveyor observed an unidentified resident ambulate past the unlocked medication cart. ULP-B opened a refrigerator and assisted another staff to place items into the refrigerator. The surveyor did not observed a ULP positioned near the medication cart or a ULP watching the medication cart. On February 20, 2024, at 11:34 a.m., the surveyor observed ULP-B removed medication for R4. The surveyor did not observe ULP-B lock the medication cart.	01880		

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01880	Continued From page 18 On February 20, 2024, at 11:44 a.m., ULP-B left the medication cart unlocked, and walked across the dining room to get a resident a cup of coffee. The surveyor did not observe ULP-B lock the medication cart. The surveyor did not observe a ULP positioned near the medication cart or a ULP watching the medication cart. On February 20, 2024, at 11:56 a.m. the surveyor observed ULP-B wash her hands at a sink in the dining area. ULP-B's back was to the medication cart. The surveyor did not observe ULP-B lock the medication cart. The surveyor did not observe a ULP positioned near the medication cart or a ULP watching the medication cart. On September 20, 2024, at 11:58 a.m., the surveyor observed licensed practical nurse (LPN)-D enter the dining area and remove a container of Thick-it (used to thicken beverages) out of the unlocked medication cart for R6. The surveyor did not observe LPN-D lock the medication cart. The surveyor observed LPN-D exit the dining area. The surveyor did not observe a ULP positioned near the medication cart or a ULP watching the medication cart. On February 20, 2024, at 12:14 p.m., the surveyor observed ULP-B remove R4's noon medication from the medication cart. The surveyor did not observe ULP-B lock the medication cart. ULP-B left the dining room area and took the medication cup up to R4's room which was on the second floor. The surveyor observed 12 residents in the dining area, ULP-D, an unidentified ULP, and a kitchen personnel in the dining area. The surveyor did not observe a ULP positioned near the medication cart or a ULP watching the medication cart. On ULP-B's return	01880		

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01880	Continued From page 19 to the medication cart the cart had been locked. On February 20, 2024, at 12:23 p.m., ULP-B stated she did not need to lock the medication cart as there were two other ULPs in the dining area who, "I can have pass medications." On February 20, 2024, at 12:27 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they (ULPs) were supposed to lock the medication cart anytime they walked away from the medication cart. LALD/RN-A confirmed the medication cart should have been secured. On February 20, 2024, at 2:53 p.m., LALD/RN-A stated, I don't know why they (staff) think that it is ok to leave the medication cart unsecured. The licensee's Medication Storage policy dated July 12, 2023, noted medications managed by the licensee would be stored to prevent diversion of medications by residents or others who may have access to the medication. diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a resident's private "living space must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 20	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time sensitive medications for three of three residents (R2, R3, R7) and the licensee failed to ensure medication was maintained bearing the original prescription label with legible information for one of three residents (R3.) Further, the licensee failed to monitor for expired stock medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 20, 2024, at 9:49 a.m., the surveyor toured the facility with licensed assisted living director/ registered nurse (LALD/RN)-A, including a review of the locked medication cart. LALD/RN-A observed and confirmed the following- TIME SENSITIVE MEDICATION	01890		

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01890	Continued From page 21 -R2's opened prednisolone acetate 1% (steroid/inflammation) eye solution did not have a label which indicated the date the eye solution would expire -R3's opened pilocarpine 2% eye solution (high eye pressure) eye solution did not have a label which indicated the date the eye solution would expire -R7's opened fluticasone-salmeterol (inflammation/swelling) 250-50 micrograms (mcg) inhaler did not have a label which indicated the date the inhaler would expire. LEGIBLE INFORMATION -R3's opened latanoprost 0.005% (high eye pressure) eye solution label was not legible. EXPIRED MEDICATION -an opened bottle of Advil which was dated with an expiration date of December 2023 (expired 51 days) used as "stock" medication (could be given to any resident with an order for Advil.) Directly after the above observation, LALD/RN-A stated time sensitive medications should have expiration dates on the containers as well as opened dates. LALD/RN-A said she was not able to read R3's latanoprost label. In addition, LALD/RNA stated the stock Advil was expired and she removed the container from the medication cart. The manufacturer's instructions for prednisolone acetate dated October 2023, noted discard the bottle 28 days after opening, even if there is solution remaining. The manufacturer's instructions for pilocarpine dated December 31, 2021, noted eye drops in bottle only keep for four weeks once the bottle	01890		

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01890	Continued From page 22 has been opened. Do not use pilocarpine drops if the bottle has been open for longer than this, even if there is some solution remaining. The manufacturer's instructions for fluticasone/salmeterol dated February 1, 2024, noted throw away the inhaler when the dose counter displays 0, 30 days after opening the pouch. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 23 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R5, R4) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 20, 2024, at 9:27 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director/registered nurse (LALD/RN)-A confirmed the licensee provided treatment and therapy services to residents. R5	01940		

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01940	Continued From page 24 R5's diagnoses included total shoulder arthroplasty (replacement.) R5's service plan dated January 31, 2024, included apply ice/heat PRN (as desired or as needed.) On February 21, 2024, at 7:52 a.m., the surveyor observed licensed practical nurse (LPN)-G hand R5 paperwork for an upcoming appointment. R5's prescriber's order dated June 9, 2023, included: -apply ice to the shoulder 20 minutes, three times per day. Staff Memo found in a binder located behind the main desk dated June 20, 2023, included: R5 is about 1.5 weeks post-surgery. Staff Instructions (picture of an ice pack): Ok to have resident apply ice pack/cold pack to her shoulder for 20 minutes three times a day -remove from freezer -ensure barrier between skin and icepack/cold pack (do not place icepack/cold pack directly on the skin). Examples of barriers: wash cloth, towel, folder paper towel, pillowcase -removed icepack/cold pack from skin after 20 minutes -for disposable ice packs/cold packs-discard in trash, do not reuse -for reusable icepacks/cold packs-place back in freezer -if any redness and/or skin irritation is noted-notify nursing. R5's record did not include evidence of an individualized treatment management plan for R5's ice packs which included: -documentation of specific resident instructions	01940		

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01940	Continued From page 25 relating to the treatment or therapy of ice packs -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatment or therapy services. On February 22, 2024, at 10:13 a.m., LALD/RN-A stated the memo for R5's ice packs was not enough and confirmed R5's record did not include required information regarding ice pack application as required. R4 R4's diagnoses included major depression, anxiety, palpitations (heart), and morbid obesity. R4's service plan dated February 16, 2024, included record blood glucose PRN, to be completed by HHA (home health assistance/ULP.) On February 20, 2024, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-B remove R4's noon medication from the medication cart and go to R4's room to administer R4's medication. R4's prescriber's order dated January 22, 2024, included: -record blood glucose PRN, check blood glucose as needed with any complaint of dizziness. R4's record included, record blood glucose PRN, suites Nurse RN/LPN (licensed practical nurse) Active on November 9, 2023, this service is charted as needed (PRN) Instructions: check blood glucose as needed with any complaints of (c/o) dizziness. R4's record did not include evidence of an individualized treatment management plan for	01940		

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01940	Continued From page 26 R4's blood glucose monitoring which included: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatment or therapy services. On February 21, 2024, at 10:27 a.m., CNS-C stated only nurse's checked R4's blood glucose, therefore instructions were not necessary to be in R4's record. CNS-C asked ULP-D to demonstrate to surveyor how ULPs did not have access to the service of blood glucose monitoring. ULP-D was able to pull up the service. CNS-C stated there was an issue with their on-line service and she would contact them. On February 21, 2024, at 10:45 a.m., LALD/RN-A stated ULPs are trained on the task of monitoring blood sugars, and information should be in R4's record pertaining to the parameters or when to report to nursing. LALD/RN-A added there was currently one blood sugar monitored at the facility. The licensee's Delegation of Assisted Living Services policy dated July 12, 2023, noted when the registered nurse or licensed health professional at the facility delegated tasks to unlicensed personnel, that person ensured that prior to the delegation the unlicensed personnel the registered nurse or licensed health professional would document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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	39300	A. BUILDING: _____ B. WING _____	02/22/2024

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01950	Continued From page 27 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 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) to demonstrate the ability to follow the procedure to perform the tasks applying ice packs for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01950		

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01950	Continued From page 28 The findings include: During the entrance conference on February 20, 2024, at 9:27 a.m., clinical nurse supervisor (CNS)-C, and licensed assisted living director/RN (LALD/RN)-A confirmed the licensee provided treatment and therapy services to residents. R5's diagnoses included total shoulder arthroplasty (replacement.) R5's service plan dated January 31, 2024, included apply ice/heat PRN (as desired or as needed.) On February 21, 2024, at 7:52 a.m., the surveyor observed licensed practical nurse (LPN)-G hand R5 paperwork for an upcoming appointment. R5's prescriber's order dated June 9, 2023, included: -apply ice to the shoulder 20 minutes, three times per day. Staff Memo dated June 20, 2023, included: R5 is about 1.5 weeks post-surgery It's important she allows her shoulder to heal, but also important for her to not be seclude in her room. I've added meal trays to her room for lunch....please document in meal reminders if you deliver a meal tray. Hand written on the bottom of this memo was "sign for acknowledgement and training" There were 11 staff signatures on this page. Behind this page was a page that was stated: Staff instructions with a picture of an ice pack: Ok to have resident apply ice pack/cold pack to her shoulder for 20 minutes three times a day	01950		

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01950	Continued From page 29 -remove from freezer -ensure barrier between skin and icepack/cold pack (do not place icepack/cold pack directly on the skin). Examples of barriers: wash cloth, towel, folder paper towel, pillow care -removed icepack/cold pack form skin after 20 minutes -for disposable ice packs/cold packs-discard in trach, do not reuse -for reusable icepack's/cold packs-place back in freezer -if any redness and/or skin irritation is noted-notify nursing. There were no signatures on this page. On February 22, 2024, at 10:13 a.m., LALD/RN-A stated the memo for R5's ice packs was not enough and confirmed training and competencies were not completed for R5's ice packs as required. The licensee's Delegation of Assisted Living Services policy dated July 12, 2023, noted when the registered nurse or licensed health professional at the facility delegated tasks to unlicensed personnel, that person ensured that prior to the delegation the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each resident and was able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 30 (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 provide care and services according to acceptable health care, medical, or nursing standards by two of two unlicensed personnel (ULP)-E, ULP-B) during medication administration for R4. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 20, 2024, at 11:34 a.m., the surveyor observed ULP-B remove R4's PRN (as desired or as needed) ondansetron HCL (nausea/vomiting) 4 milligrams (mg) tablet from the medication cart positioned in the dining area of the facility. ULP-B put the medication into a medication cup and handed the medication cup to ULP-E. The surveyor observed ULP-E take the medication cup with the ondansetron 4 mg and a	02320		

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02320	Continued From page 31 glass of water and exit the dining area and walk up a flight of stairs. On February 20, 2024, at 11:38 a.m., ULP-E returned to the medication cart. The surveyor observed ULP-E report to ULP-B that R4 took the medication (ondansetron). ULP-B documented R4's ondansetron as administered. R4's prescriber order dated March 20, 2023, included: -ondansetron 4 mg tablet, by mouth, as needed, take one tablet by mouth every eight hours as needed for nausea. R4's medication administration record (MAR) dated February 1, 2024, through February 20, 2024, included ondansetron 4 mg, take one tablet (4 mg) by mouth every eight hours as needed for nausea, as administered by ULP-B on February 20, 2024, at 11:38 a.m. On February 20, 2024, at 12:23 p.m., ULP-B stated both ULP-D and an unidentified ULP were both medication passers and she (ULP-B) could have them pass medication. On February 20, 2024, at 12:27 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated "we" (facility) do not teach ULPs to administer medication "that" way. LALD/RN-A stated one person administers medications. LALD/RN-A stated staff went "rogue" and added ULP-B would be retrained on medication administration. On February 20, 2024, at 12:31 p.m., LALD/RN-A said, "we" (facility/ULP) do not set up medication and then have someone else (another staff) deliver the medication.	02320		

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02320	Continued From page 32 The licensee's Medication Management-Administration & Set up policy dated July 12, 2023, noted assistance with medication and medication administration would be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and tile of the person who provided the medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted	02410		

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02410	Continued From page 33 discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for one of four residents (R3) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses include chronic angle closure glaucoma of right eye (high eye pressure,) major depressive disorder, mood disorder, and generalized anxiety disorder. R3's service plan dated February 1, 2024, indicated R3 received medication administration five times daily. On February 20, 2024, at 11:08 a.m., the surveyor observed unlicensed personnel (ULP)-B go to a medication cart which was positioned in the main entryway of the facility which flowed into a small common's area/TV area. ULP-B opened the lap top computer placed on top of the medication cart. ULP-B looked at R3's electronic	02410		

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02410	Continued From page 34 medication record (EMAR.) ULP-B removed an amber plastic medication container (pill like bottle) from the medication cart. ULP-B opened the plastic medication container which had R3's name and medication information (prescription label,) and removed a bottle of pilocarpine eye solution (high eye pressure) 2% for R3 from the container. ULP-B placed the plastic medication container on top of the medication cart after she removed the eye solution. ULP-B left the medication cart and walked over to a chair in the TV area in the entry/ common's area and ULP-B handed the eye solution to R3, and R3 instilled one drop into R3's right eye. ULP-B returned to the medication cart and picked up the amber plastic container and placed R3's eye medication back into the bottle. ULP-B placed the plastic container back into the medication cart. ULP-B documented R3's medication as given. On February 20, 2024, at 11:28 a.m., ULP-B stated it was "normal" to leave the plastic medication container on top of the medication cart when she administered R3's eye solution. On February 20, 2024, at 12:30 p.m., licensed assisted living director/ registered nurse (LALD/RN)-A stated ULP-B should not have left the bottle (container) for R3's eye medication on top of the medication cart and walked away. LALD/RN-A said ULP-B should have removed the medication from the bottle (container) and placed the container in the medication cart, after medication administration the eye medication should have been placed back into the container, which has been stored within the medication cart. The licensee's Confidentiality policy dated July 12, 2023, noted the licensee takes confidentiality of information very seriously. Personal, financial,	02410		

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02410	Continued From page 35 medical, or other private information regarding residents or staff should not be disclosed to any other person except: -as may be required by law -to other staff as appropriate or necessary to provide services -to persons authorized in writing by the resident or resident's responsible person to receive the information, including third party payers or -to representatives of the commissioner authorized to survey or investigate any part of the community. It is an employee's responsibility to stop co-workers for other staff from discussing inappropriate resident or staff information in public areas. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to have personal, financial, health, and medical information kept private. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/20/24*
Time: 11:00:00
Report: 7983241049

Food and Beverage Establishment Inspection Report

Location:
Hillcrest Suites
1520 East Highway 37
Hibbing, MN55746
St. Louis County, 69

Establishment Info:
ID #: N000214
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-201.11A ***** Priority 1 *****

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

HAND SANITIZER WAS STORED ON THE PLASTIC CABINET IN WHICH PLATES, CUPS, ETC. WERE STORED IN THE DINING AREA. THE SANITIZER WAS MOVED TO A MORE APPROPRIATE LOCATION.

Comply By: 02/20/24

Food and Equipment Temperatures

Process/Item: Refrigerator/Freezer
Temperature: 37 Degrees Fahrenheit - Location: Air temperature of the refrigerator compartment of the Frigidaire refrigerator/freezer.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 154 Degrees Fahrenheit - Location: Broccoli.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: Swiss pork chops.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: Baked potatoes.
Violation Issued: No

Type: Full
Date: *02/20/24*
Time: 11:00:00
Report: 7983241049
Hillcrest Suites

Food and Beverage Establishment Inspection Report

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

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GENERAL COMMENTS:

1) Food is prepared in the kitchen of Hillcrest Terrace, and it is transported to Hillcrest Suites.

2) Leftovers are saved. Discussed cooling.

3) Provided a handwashing fact sheet. See the section on hand antiseptics.

==========

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983241049 of 02/20/24.

Certified Food Protection Manager: Holli Johnson

Certification Number: FM62527 Expires: 06/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Holli Johnson
Person in Charge

Signed: 7983

651-201-4500
health.foodlodging@state.mn.us