Electronically Delivered

June 22, 2023

Licensee
Direct Home Care Services LLC
19449 Rush Street Northwest
Elk River, MN 55330

RE: Project Number(s) SL38050015

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 May 16, 2023, 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 and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this survey of your facility.

DOCUMENTATION OF ACTION TO COMPLY
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.

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

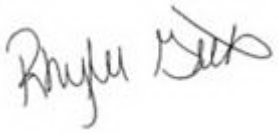
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38050	A. BUILDING: _____ B. WING _____	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIRECT HOME CARE SERVICES LLC	19449 RUSH STREET NORTHWEST ELK RIVER, MN 55330

(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: SL#38050015 On May 15 and 16, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there was one resident receiving services under the provider's Provisional Assisted Living Facility 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 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to develop and implement a staffing plan which included an evaluation, to be conducted at least twice a year, of appropriateness of staffing levels in the facility. This deficient practice affected all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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: The licensee was issued a Provisional Assisted Living Facility license (PALF) effective April 4, 2022 to April 3, 2023. During the entrance conference on May 15, 2023, at 9:45 a.m., the owner, (OW)-A, said he was familiar with current assisted living laws and regulations. OW-A said he was in the process of developing a staffing plan and policies on scheduling and staffing, but they only had one resident currently so he scheduled two staff members on days and one staff member on nights. During the licensee tour on May 15, 2023, at 10:40 a.m., the Minnesota Department of Health (MDH) surveyor observed a staff schedule posted near the licensee entrance but no staffing plan. TIME PERIOD TO CORRECT: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 3 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. 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 MDH Food and Beverage Establishment Inspection Report dated May 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 4 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure their Appendix Z Emergency Preparedness Plan (EPP) was prominently posted and contained all required components. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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:	0 680		

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0 680	Continued From page 5 The licensee was issued a Provisional Assisted Living Facility license (PALF) effective April 4, 2022 to April 3, 2023. During the entrance conference on May 15, 2023, at 9:45 a.m., the owner, (OW)-A, said he was familiar with current assisted living laws and regulations. During the licensee tour on May 15, 2023, at 10:40 a.m., the Minnesota Department of Health (MDH) surveyor did not observe an EPP prominently posted. During an interview on May 15, 2023, at 12:25 p.m., OW-A said he had some of the EPP completed, but could not find it on his computer. OW-A said he had done fire drills with some staff but thought he just needed to follow an "MDH checklist" and did not need to document details on fire drills. On May 16, 2023 at 9:20 a.m., OW-A produced a plastic folder he said contained some of the EPP policies and procedures he could not find the day before. The licensee's EPP lacked: - policies and procedures specific to the licensee. "Love and Care" was listed as the licensee on several EPP policies and procedures, not "Direct Home Care Services". -consideration of emerging infectious diseases -a risk hazards assessment -identification of at risk population needs such as maintaining independence, communication, transportation, supervision and medical care. -delegations of authority listed OW-A in some sections, but other names were listed on different pages. The other names were not on the current	0 680		

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0 680	Continued From page 6 staff roster. - process for cooperation and collaboration with local, tribal, regional, State and Federal EPs. -developed polices and procedures based on the EP, risk assessment and communication plan -subsistence needs for staff and residents: food, medical supplies, pharmaceutical supplies -procedure for tracking on duty-staff and sheltered residents -treatment/care needs of evacuees, transportation, evacuation locations -the EPP listed two out of three sites as "primary evacuation sites", but did not indicate if staff and residents would split up and go to different sites or remain together and go to one of the three sites -sheltering in place for residents, staff and volunteers -policies and procedures to address system of medical documentation that preserves resident information, protects confidentiality and secures records. -use of volunteers including process/role for integration -arrangements with other facilities to receive residents, limitations, cessation of operations and continuity of services, no arrangement agreements -role under a facility 1135 waiver declared by the Secretary -a communication plan -current names and contact information for staff; some names not part of current staff roster, phone number's missing -primary and alternate means of communication with facility staff, Federal, State, tribal and local EMS -methods for sharing information and medical documentation for residents -sharing and occupancy needs	0 680		

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0 680	Continued From page 7 -emergency preparedness training program -emergency preparedness testing requirements -information if licensee is part of an integrated healthcare system During the exit interview on May 16, 2023, at 2:40 p.m., OW-A said some of the names on the EPP who were not listed as current staff were people he knew. A policy titled Emergency Preparedness Evacuation, undated, was not part of the licensee's EPP folder. The policy indicated the facility would establish and maintain guidelines in planning resident evacuations. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 8 Based on observation and interview, the licensee failed to maintain facility fire extinguishers. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on May 15, 2023, between 11:45 a.m. and 12:45 p.m., survey staff toured the facility with the Owner (OW)-A, and observed the fire extinguishers were expired in January 2023. OW-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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.	0 800		

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0 800	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, between 11:45 a.m. and 12:45 p.m., survey staff toured the Owner (OW)-A. During the facility tour, survey staff observed the following: 1. There is no grab bars installed in the in any of the bathrooms. 2. There are 3 out of 5 light bulbs missing in the Master Bathroom. OW-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 10 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training	0 810		

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0 810	Continued From page 11 on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, 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 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2023 between 11:45 a.m. and 12:45 p.m., survey staff toured the facility with the Owner (OW-A). During the facility tour, OW-A failed to provide documents for review. Documents were reviewed by survey staff on May 15, 2023 between 11:45 a.m. and 12:45 p.m., 1. Evacuation maps were not available at the time of the survey. 2. The licensee failed to provide unique or unusual resident needs for movement or evacuation. 3. The licensee failed to provide employee training logs for fire safety and evacuation. 4. The licensee failed to provide the required employee training frequency. 5. The licensee failed to provide annual fire safety and evacuation training for residents. 6. The licensee failed to provide an evacuation plan in or near current residents room. OW-A -A verbally confirmed survey staff	0 810		

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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
0 810	Continued From page 12 observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01450 SS=F	144G.62 Subd. 5 Documentation A facility must retain documentation of supervision activities in the personnel records. This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to retain documentation of supervision activities in the personnel records for three of three staff members, owner (OW)-A, unlicensed personnel (ULP)-E, and ULP-F, with review of personnel records. 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: The licensee was issued a Provisional Assisted Living Facility license (PALF) effective April 4, 2022 to April 3, 2023. During the entrance conference on May 15, 2023,	01450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38050	A. BUILDING: _____ B. WING _____	05/16/2023

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01450	Continued From page 13 at 9:45 a.m., the owner, (OW)-A, said he was familiar with current assisted living laws and regulations. On May 15, 2023, at 12:45 p.m., ULP-E said she received training from registered nurse (RN)-B on R1's medication administration. On May 16, 2023, at 8:50 a.m., the MDH surveyor observed OW-A provide direct cares to R1 when he administered her morning medications. On May 16, 2023, at 9:45 a.m., the MDH surveyor observed ULP-F wrap R1's legs with compression bandages. ULP-F said she was trained on the leg wraps but R1 liked how ULP-E wrapped them better because she worked with R1 more often. ULP-E arrived and unwrapped R1's compression bandages so she could help R1 with her shower. On May 16, 2023 at 10:45 a.m., the MDH surveyor observed ULP-E rewrap R1's legs with compression bandages. OW-A's hire date was August 21, 2021. Review of OW-A's personnel record lacked any supervisory documentation by an RN regarding the delegated services. ULP-E's hire date was March 24, 2023. Review of ULP-E's personnel record lacked any supervisory documentation by an RN regarding the delegated services. ULP-F's hire date was March 24, 2023. Review of ULP-F's personnel record lacked any supervisory documentation by an RN regarding the delegated services.	01450		

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01450	Continued From page 14 During an interview on May 16, 2023, at 10:45 a.m., ULP-E said RN-B trained her and ULP-F on R1's compression bandage leg wraps. During an interview on May 16, 2023, at 1:28 p.m., OW-A said there were trainings documented in the employee files and on-line computer module trainings, but he did not know the nurses needed supervision documentation for the staff members. A policy titled Personnel Records, undated, indicated personnel files needed to include, but was not limited to: evidence of current and professional licensure, registration, or certification; records of orientation to the facility, the licensee and employee roles and responsibilities; records of annual training and competency evaluations. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01450		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed ensure staff members providing assisted living services were specifically oriented to the resident (R1) and the services provided for three of three staff, OW-A, ULP-E and ULP-F, reviewed for orientation.	01480		

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01480	Continued From page 15 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: The licensee was issued a Provisional Assisted Living Facility license (PALF) effective April 4, 2022 to April 3, 2023. During the entrance conference on May 15, 2023, at 9:45 a.m., owner (OW)-A, said he was familiar with current assisted living laws and regulations. OW-A's hire date was August 21, 2021. Review of OW-A's personnel record lacked any documentation on how he was oriented to R1 and her services. ULP-E's hire date was March 24, 2023. Review of ULP-E's personnel record lacked any documentation on how she was oriented to R1 and her services. ULP-F's hire date was March 24, 2023. Review of ULP-F's personnel record lacked any documentation on how she was oriented to R1 and her services. R1 admitted to the licensee on March 26, 2023. R1's diagnoses included atrial fibrillation and heart murmur.	01480		

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01480	Continued From page 16 On May 16, 2023, at 8:50 a.m., the MDH surveyor observed OW-A provide direct cares to R1 when he administered her morning medications. On May 16, 2023, at 9:45 a.m., the MDH surveyor observed ULP-F wrap R1's legs with compression bandages. ULP-F said she was trained on the leg wraps but R1 liked how ULP-E wrapped them better because she worked with R1 more often. ULP-E arrived and unwrapped R1's compression bandages so she could help R1 with her shower. On May 16, 2023, at 10:45 a.m., the MDH surveyor observed ULP-E rewrap R1's legs with compression bandages. During an interview on May 15, 2023, at 12:45 p.m., ULP-E said she received training from registered nurse (RN)-B on R1's medications. During an interview on May 16, 2023, at 1:28 p.m., OW-A said RN-B and RN-C oriented staff members to R1, but did not document the verbal orientation. The licensee did not have a policy on staff orientation to the resident. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01480		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 17 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the service plan included a description of the services to be provided and the fees for services for one of one resident (R1) reviewed. 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	01650		

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01650	Continued From page 18 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on March 26, 2023. R1's diagnoses included atrial fibrillation and heart murmur. R1's service plan dated March 26, 2023, included a "Description of Services" column that listed "Medications", "Reminders", and "Administration", each with a check box. All three boxes were not checked. In the next column, "Frequency", someone had written "4 x daily". The "Fee for Service" columns were blank for all 17 pre-printed services that R1 received or could receive. R1's service plan included language which read: "Fee for services included in a package or provided by EW/CADI or other fee structure are attached." There was no EW/CADI or other fee structure attached to R1's service plan. A line titled "Service Rate" was blank. Below, was handwritten "not negotiated yet". During an interview on May 16, 2023, at 1:28 p.m., OW-A said he was waiting for the county to determine the fee rate because the licensee could not go over a certain dollar amount. OW-A said he was not sure what they were charging R1 who was on an elderly waiver. OW-A said there were no service fees listed on R1's service plan and no county fees attached to her service plan. A policy titled Service Plan, undated, indicated assisted living services will be provided according to a suitable and current service plan and to	01650		

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01650	Continued From page 19 inform the resident or representative of the types of services provided, fees for services and the type and frequency of visits/services proposed according to the resident's assessments and preferences. TIME PERIOD TO CORRECT: Seven (7) Days	01650		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to have an up-to-date written or electronically recorded order form from an authorized prescriber for compression leg wraps for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01970		

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01970	Continued From page 20 The Findings include: R1 admitted to the licensee on March 26, 2023. R1's medical diagnoses included atrial fibrillation, heart murmur and lymphedema (tissue swelling due to accumulation of protein-rich fluid that is isusually drained by the lymphatic system). R1's service plan, dated March 26, 2023, indicated R1 needed her legs elevated daily. R1's Treatment/Therapy Management Plan dated March 26, 2023, indicated services provided or delegated to unlicensed personnel (ULPs), included "encourage to elevate lower extremities" in the space marked "other". The check box for lymphedema wraps was not checked. R1's treatment order dated April 1, 2023, was signed by R1's primary care provider (PCP). The order instructed staff members to elevate R1's lower extremities (legs) daily and report swelling of her legs to the RN immediately. There was no PCP order for compression leg wraps. The treatment order to elevate R1's legs was effective 2023 to 2024. On May 15, 2023, R1's family member (FM)-G said R1's insurance denied payment for lymphedema leg wraps ordered by a provider before R1 moved to the licensee. Her family decided to use compression bandages instead. FM-G said there was no current physician order for R1's compression leg wraps. On May 16, 2023, at 9:45 a.m., the MDH surveyor observed ULP-F wrap R1's legs with compression wraps. ULP-F said she was trained on the compression leg wraps, but R1 liked how ULP-E wrapped them better because she worked	01970		

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01970	Continued From page 21 with R1 more often. ULP-E arrived and unwrapped R1's compression bandages so R1 could shower. On May 16, 2023, at 10:45 a.m., the MDH surveyor observed ULP-E rewrap R1's legs with compression wraps. ULP-E said the nurse trained them on wrapping R1's legs, but there were no instructions on how long R1 needed her legs compression wrapped or elevated. A policy titled Treatment and Therapy Management Plan, undated, indicated orders must be obtained for treatments or therapies that would require orders from an authorized provider before the services are provided. Treatments and therapies shall be administered by facility staff only as ordered by the physician or designated provider. TIME PERIOD TO CORRECT: Seven (7) Days	01970		

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

Type: Full
Date: *05/15/23*
Time: 11:05:43
Report: 7930231107

Food and Beverage Establishment Inspection Report

Location:
Direct Home Care Services
19449 Rush Street NW
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0041397
Risk:
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

AT TIME OF INSPECTION DISHES WERE DRYING IN THE DRYING RACK AND WERE NOT BEING RUN THROUGH THE DISHWASHER. ALL DISHES MUST BE RUN THROUGH THE DISHWASHER ON THE SANITIZING CYCLE EVERY TIME.

Comply By: 05/15/23

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE A THERMOMETER WITH A THIN TAPERED END TO MEASURE COOKING TEMPERATURES OF FOOD.

Comply By: 05/22/23

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PROVIDE PAPER TOWELS FOR THE HANDWASHING SINK IN THE KITCHEN. AT TIME OF

INSPECTION THERE WAS ONLY TOILET PAPER AVAILABLE AND BEING USED TO DRY HANDS.
Comply By: 05/15/23

2-100 Supervision

2-102.12AMN

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

LIKE STATED ABOVE. MANAGER STATED THE EMPLOYEES HAVEN'T PASSED THE CLASS YET. ONE FULL TIME EMPLOYEE WORKING IN FOOD SERVICE NEEDS TO TAKE THE CLASS AND GET THE STATE CERTIFICATE. CFPM APPLICATION EMAILED WITH REPORT.
Comply By: 07/01/23

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

**DIRECT HOME SERVICES IS NOT LICENSED TO MAKE FOOD AND STORE IT FOR SERVICE THE NEXT DAY. ALL FOOD MUST BE PREPARED, SERVED AND DISCARDED DAILY.
**PROVIDE SINGLE USE FOOD SAFE GLOVES FOR USE IN THE KITCHEN. AT TIME OF INSPECTION THERE WAS EXAMINATION GLOVES ON SITE.

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 7930231107 of 05/15/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us