



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 14, 2023

Licensee
Highview Home Care LLC
1460 Farrington Street
Saint Paul, MN 55117

RE: Project Number(s) SL39298015

Dear Licensee:

On November 30, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 13, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 13, 2023 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 13, 2023, found not corrected at the time of the November 30, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - \$500.00

1820-Prescriptions-144g.71 Subd. 13

1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3

1970-Treatment And Therapy Orders-144g.72 Subd. 6

The details of the violations noted at the time of this follow-up survey completed on November 30, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans

of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized, flowing script.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/30/2023
NAME OF PROVIDER OR SUPPLIER HIGHVIEW HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1460 FARRINGTON STREET SAINT PAUL, MN 55117		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL39298015-1 On November 27, 2023, through November 30, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 13, 2023. At the time of the survey, there were three residents: three receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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.		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	{01650}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{01650}	Continued From page 1 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	{01650}			

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{01650}	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 27, 2023, at 12:00 p.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they had worked with a consultant through Residex (their newly acquired electronic medical record system) and thought the Service Plans included all the required elements. R1 R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 17, 2023. R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related) convulsions (seizures). R1's Service Plan dated November 27, 2023, indicated she received services of medication assistance/administration, insulin draws, bathing, grooming, wound care, toileting assistance, housekeeping and mental health management. On November 28, 2023, at 11:35 a.m. unlicensed personnel (ULP-C) was observed to complete a blood sugar check and administer insulin to R1. R1 was observed to have a wound vac unit (an electronic appliance which provides suction to a deep tissue wound to promote healing) in place. R1 stated the wound vac had much improved her buttock wound.	{01650}			

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{01650}	Continued From page 3 R2 R2 was admitted to the facility under the facility's ALF license on March 1, 2023. R2's diagnoses included type two diabetes (when the body cannot adequately manage insulin production and control blood sugar) and alcoholic hepatitis (liver disease associated with excess alcohol consumption). R2's Service Plan dated November 28, 2023, indicated R2 received services of medication administration, bathing, grooming, toileting, blood sugar checks and behavior management. R3 R3 was admitted to the facility under the facility's ALF license on April 17, 2023. R3's diagnoses included atherosclerotic heart disease (hardening of the blood vessels causing impaired heart function). R3's Service Plans dated April 17, 2023, and November 28, 2023, were provided. The Service Plans indicated R3 received the services of medication administration, assistance with bathing, grooming and behavior management. R1, R2, and R3's Service Plans lacked the required content of: (1) the fees for services, (2) the schedule and methods of monitoring assessments of the resident; (3) the schedule and methods of monitoring staff providing services; and (4) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	{01650}			

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{01650}	Continued From page 4 (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. On November 28, 2023, at 11:57 a.m., CNS-B stated he now reviewed the Service Plan content as created through Residex and it didn't appear to include all the required content. He stated he was able to find a template through a different resource and attempted to update each of the resident's Service Plans to include the required content, however the detail of the Service Plans remained incomplete. The licensee's Service Plan policy dated December 1, 2022, indicated the service plan would include: -The fees for services -The schedule and methods of monitoring assessments of the resident -The schedule and methods of monitoring staff providing services -The extent to which payment may be expected from a third-party payer -The charges for services that will not be covered by a third-party payer -The charges the individual may have to pay -A contingency plan for circumstances when services cannot be provided	{01650}			

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{01650}	Continued From page 5 5. Plan for contingency action shall include: a. The action to be taken by the provider if scheduled services cannot be provided b. Information and a method for a resident or their representative to contact the facility c. Name and contact information of persons the resident wished to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification and information as to who has authority to sign for the resident in an emergency d. 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. 6. A medical emergency plan is established which identifies any advance directives the resident might have made as well as code status. The Service Plan shall be signed by the resident or financially responsible party. 8. The resident shall be advised, orally and in writing, of any changes in type or frequency of services or fee schedule. This advisement shall occur as soon as possible after the facility becomes aware of the change. Written notice will be given by making the appropriate changes on the Service Plan and obtaining resident/representative signature or initials. 9. The original Service Plan and any revised service plan must be entered into the resident record, including notice of a change in fees when applicable. 10. Changes in types of services or fees will be based on assessment of the resident or resident preferences and reviewed with the resident/representative and noted on the Service Plan, as appropriate. All changes in the Service Plan must be acknowledged by the resident.	{01650}			

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{01650}	Continued From page 6 No further information was provided.	{01650}			
{01820} SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's Service Plan dated November 28, 2023, indicated he received services to include medication administration. On November 28, 2023, at 9:30 a.m. unlicensed personnel (ULP)-C stated she assisted R2 with daily blood sugar checks and medication	{01820}			

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{01820}	Continued From page 7 administration. R2's Medication Administration Record (MAR) dated November 2023, indicated he received one oral medication for diabetes (when the body cannot effectively manage blood sugars and insulin production), one injection for diabetes, one for blood pressure, one for acid reflux, one for mild pain, three supplements, and one eye drop for glaucoma (a condition where the inner eye has high pressure leading to blindness). R3 R3's Service Plan dated November 28, 2023, indicated he received services to include medication administration. On November 28, 2023, at 9:45 a.m. ULP-C stated she assisted R3 with medication administration at various times through the day. R3's MAR dated November 2023, indicated he received one medication for cholesterol, one for blood pressure, two to regulate heart rhythm, one blood thinner, one for improved blood flow, one antiviral, one inhaler for asthma, one for acid reflux, one antacid, and one topical medication for hemorrhoids. On November 28, 2023, at 11:40 a.m. clinical nurse supervisor (CNS)-B provided the surveyor R3's transfer summary dated April 16, 2023, and stated this was the document the licensee used as orders from R3's previous assisted living provider. The document listed medications but lacked a signature from a physician or an authorized provider. CNS-B stated with R3's transfer to their facility, they just worked with the pharmacy to transfer medications. CNS-B stated he could not find signed orders and was now	{01820}			

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{01820}	Continued From page 8 working with the pharmacy to gather appropriate signed orders. Furthermore, CNS-B stated he was unable to locate signed orders for R2. The licensee's Medication Prescriptions and Refills policy dated December 1, 2022, indicated A current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. Upon receiving verbal orders, the RN or LPN will record and sign the verbal order and forward the order to the prescriber for a signature. The RN or LPN will continue to follow up with the prescriber's office or the pharmacy until a signed prescription/ verbal order is received and will document all efforts to obtain a signature. No further information was provided.	{01820}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must 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	{01940}			

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{01940}	Continued From page 9 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include all required content for one of one resident (R1). 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin,	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 10 chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated November 27, 2023, indicated she received the services of blood sugar checks, medication administration, insulin pen management, and wound care. On November 27, 2023, at 12:40 p.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated R1 had a wound vac appliance which was managed by a home health agency. R1's Service Plan dated November 27, 2023, indicated she received the service of wound care. On November 27, 2023, at 12:05 p.m. R1 was observed to be escorted by unlicensed personnel (ULP)-C to the restroom. ULP-C was observed to follow R1 and carried a wound vac appliance (an electronic appliance which provides suction to a deep tissue wound to promote healing) attached to R1. R1's Treatment plan dated November 8, 2023, indicated the treatment of blood sugar checks but lacked the treatment of wound care, the presence of a wound vac as managed by a home health agency. Furthermore, the treatment plan lacked written instruction/direction for staff if the wound vac was not properly functioning, nor the steps to provide wet to dry dressings if needed (in the interim of waiting for the home health nurse to come to the facility to manage a wound vac dressing change). On November 27, 2023, at 2:45 p.m. CNS-B stated the home health agency managed all of R1's wound care with the wound vac and came to the facility every two to three days. The licensee's	{01940}			

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{01940}	Continued From page 11 staff were to ensure the wound vac was functioning and if it alarmed, knew the steps to trouble shoot. If the wound vac dressing were to come loose or fall off, they were to provide wet to dry dressings to the area to protect the wound and call the home care agency for further assistance. CNS-B stated they had not yet needed to manage this step. CNS-B stated he had not added this information to R1's treatment plan. The licensee's Treatment and Therapy Plan policy dated December 1, 2022, indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided. b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services. e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented. No further information was provided.	{01940}			
{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	{01970}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HIGHVIEW HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1460 FARRINGTON STREET SAINT PAUL, MN 55117		
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{01970}	Continued From page 12 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 observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2's diagnoses included type 2 diabetes (when the body cannot effectively manage insulin production to regulate blood sugar). R2's Service Plan dated November 28, 2023, indicated R2 received the service of daily blood sugar checks. On November 28, 2023, at 9:00 a.m. unlicensed personnel (ULP)-C stated she had completed a blood sugar check earlier in the morning.	{01970}			

Minnesota Department of Health

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{01970}	Continued From page 13 R2's Service Recap Summary dated November 2023, indicated he received blood sugar checks daily. R2's record lacked orders for the treatment of blood sugar checks. On November 28, 2023, at 11:40 a.m. clinical nurse supervisor (CNS)-B provided the surveyor R3's transfer summary dated April 16, 2023, and stated this was the document the licensee used as orders from R3's previous assisted living provider. The document listed medications but lacked a signature from a physician or an authorized provider. CNS-B stated he was unable to locate an order for R2's blood sugar checks. The licensee's Treatment and Therapy Management Plan policy dated December 1, 2022, indicated when the nurse/therapist received a verbal order from the physician/authorized prescriber, he/she shall immediately record and sign the telephone order form and obtain the prescriber's countersignature. It is the facility's responsibility to send telephone orders to the physician or authorized prescriber for signature as soon as possible after receipt of the verbal order. A system will be used by the facility to ensure that the telephone orders are signed and dated by the physician/prescriber and returned to the resident's clinical record within an appropriate time frame. The Nurse/Therapist shall document implementation of order changes and instructions given and all physician/prescriber orders shall be maintained in the clinical record. The order must contain the name of the resident, a description of the treatment or therapy and frequency and any other information needed to administer the treatment or therapy.	{01970}			

Minnesota Department of Health

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{01970}	Continued From page 14 No further information was provided.	{01970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 9, 2023

Licensee
Highview Home Care LLC
1460 Farrington Street
Saint Paul, MN 55117

RE: Project Number(s) SL39298015

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 September 13, 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.

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.

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,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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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: SL39298015-0 On September 11, 2023, through September 13, 2023, 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 three active residents; three were 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.		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of one unlicensed personnel (ULP-C) during a blood sugar check and 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 11, 2023, at 12:15 p.m. ULP-C was observed to wash her hands, donned (applied) gloves and used her key to unlock the medication drawer labeled with R1's name. ULP-C removed R1's medication crate, selected R1's prepackaged Gabapentin (for nerve pain)	0 510			

Minnesota Department of Health

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0 510	Continued From page 2 and placed two tablets into a medication cup. ULP-C gave R1 her oral medications and set up a paper towel on the kitchen table to provide a blood sugar check. ULP-C placed R1's glucometer (a machine used to test blood sugars) on the paper towel, prepared the test strip, lancet (used to poke R1's finger for a blood sample), and an alcohol wipe. ULP-C asked R1 which finger she wanted to draw blood from, R1 indicated her preference of the third finger of her left hand. ULP-C wiped the finger with an alcohol wipe, allowed it to dry for a few seconds, and then poked the finger with the lancet tool, drew blood and placed the glucometer strip against R1's finger to obtain a drop of blood. The glucometer indicated a blood sugar of 209. ULP-C placed the test strip and lancet in the sharps container. With the same gloved hands, ULP-C prepared R1's Novolog insulin pen by wiping the pen tip with an alcohol wipe, placed a new needle to the pen tip, primed the insulin pen with the designated two units of insulin, and dialed the pen to five units of insulin as per R1's insulin sliding scale. ULP-C assisted R1 with wiping her abdomen and handed the insulin pen to R1 who then self-administered the insulin. ULP-C took the insulin pen, removed and disposed of the needle, put supplies away in R1's medication drawer, and documented the blood sugar level and insulin given in the medications book. ULP-C then removed her gloves, disposed of them, and washed her hands. ULP-C failed to remove her gloves and sanitize her hands immediately following assisting R1 with a blood sugar check (where she may have been in contact with R1's blood) and touched several surfaces before she removed her gloves and sanitized her hands. On September 11, 2023, at 12:45 p.m. ULP-C	0 510			

Minnesota Department of Health

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0 510	Continued From page 3 stated she did not think about removing her gloves between the steps of checking R1's blood sugar, handling the insulin pen, touching multiple surfaces, and documenting in the medication book. The licensee's Standard Precautions policy dated December 1, 2022, indicated, "Gloves should be changed after each resident contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing." Additionally, the policy included: 1. Assume that blood and all body fluids, with or without visible blood, from all residents are potentially infectious. 2. WASH HANDS 3. GLOVES, such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment; when having direct contact with blood, body fluids, mucous membranes, or non-intact skin; when handling items soiled with blood; or when handling equipment contaminated with blood or body fluids. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630			

Minnesota Department of Health

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0 630	Continued From page 4 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). 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: R1 R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 17, 2023. R1's Service Plan dated March 17, 2023, indicated she received services of medication assistance/administration, insulin draws, bathing,	0 630			

Minnesota Department of Health

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0 630	Continued From page 5 grooming, toileting assistance, housekeeping and mental health management. Additionally, R1's undated/unsigned, Service Plan Modification indicated she received the services of blood sugar checks three times daily and assistance with transfers. On September 11, 2023, at 12:15 p.m. unlicensed personnel (ULP)-C was observed to prepare and administer R1's Gabapentin (for nerve pain), complete a blood sugar check, and prepare R1's Novolog insulin pen to the appropriate dose according to R1's insulin sliding scale (an adjustable range of insulin units dependent on a person's blood sugar level). ULP-C stated, "R1 is more confused and forgets things more now. We are helping her more and more." R1's Individual Abuse Prevention Plan (IAPP) dated March 17, 2023, indicated "no" as the answer to "Resident is at risk of abuse by others." Additionally, to the question of "resident is dependent on caregiver" the response was "no". Finally, the document included the line with a checked box, which read "Resident is considered vulnerable but there are no signs of abuse or neglect." The licensee failed to indicate R1's susceptibility to abuse by others as a vulnerable adult and failed to accurately depict her dependence on caregivers. On September 13, 2023, at 10:30 a.m. clinical nurse supervisor (CNS)-B stated he thought since R1 and other residents could express themselves and verbalize, they were not vulnerable/susceptible to abuse by others including other vulnerable adults. CNS-B and licensed assisted living director (LALD)-A then stated their understanding that all residents who received services under their assisted living	0 630			

Minnesota Department of Health

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0 630	Continued From page 6 license would be considered vulnerable adults and susceptible to abuse or neglect. The licensee's Individual Abuse Prevention policy dated December 1, 2022, indicated all residents admitted to the facility would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650		

Minnesota Department of Health

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0 650	Continued From page 7 (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 included evidence of training/competency content for insulin pen injection and wound care for one of one unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on October 8, 2022, to provide direct care services to residents of the facility. Insulin competency On September 11, 2023, at 12:15 p.m. ULP-C was observed to complete R1's blood sugar check, and prepare R1's Novolog insulin pen to the appropriate dose according to R1's insulin sliding scale (an adjustable range of insulin units dependent on a person's blood sugar level).	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 ULP-C stated she was trained by the licensee's registered nurse (RN) and stated he had watched her perform/assist R1 with her insulin pen injection after she moved in. ULP-C's employee file contained medication administration training/competency records dated March 1, 2023, and signed by clinical nurse supervisor (CNS)-B. The medication competency included only oral medication administration and lacked signed competency as observed by the RN for insulin pen administration or other routes of medication administration. Wound Care competency On September 12, 2023, at 8:45 a.m. ULP-C was observed to provide wound care to R1. ULP-C removed a previous dressing, cleansed the wound with spray cleanser and gauze, and covered the wound with a clean adhesive edged dressing. ULP-C stated the licensee's RN had trained all staff, provided written instructions, and watched her complete wound care/dressing change with R1. ULP-C's employee record lacked evidence of training/competency by the licensee's RN. On September 13, 2023, at 10:30 a.m. clinical nurse supervisor (CNS)-B stated he had provided training to all staff regarding insulin pen injections and other routes of medication administration, and had trained and observed ULP perform wound care, stating, "I'm at the house very often and watch staff do everything." CNS-B stated he did not know if or where this was documented. The licensee's Employee Records policy dated December 1, 2022, indicated the employee	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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0 650	Continued From page 9 record must contain records of orientation, required annual training, infection control training and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in one of one resident's record (R1) were authenticated by the title of the person making the entry. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1's Individual Abuse Prevention Plan dated September 5, 2023, included the registered	0 690			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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0 690	Continued From page 10 nurse's name, but lacked his credentials/title. R1's Treatment Plan and Medication Assessment for Self-Administration dated March 17, 2023, included the registered nurse's name, but lacked his credentials/title. R1's undated, Service Plan Modification included the registered nurse's name but lacked his credentials/title. R1's unnamed document, known as R1's task record, dated September 2023, included several initials and illegible signatures, and lacked staff credentials/titles. R1's daily staff progress note entries dated June 1, 2023, through September 11, 2023, included various staff initials; however, the record lacked staff names and credentials/titles. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A stated they recognized the lack of staff credentials with various documents and were receiving training in a new electronic medical record system. CNS-B and LALD-A stated all other resident records would also lack staff credentials/titles. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730			

Minnesota Department of Health

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0 730	Continued From page 11 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730			

Minnesota Department of Health

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0 730	Continued From page 12 status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of content in the resident's record as required for one of one resident (R1). 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: R1's Service Plan dated March 17, 2023, and R1's unsigned/undated, Service Plan Modification included the services of medication management, blood sugar checks, insulin draws, assistance with bathing, dressing, and toileting. On September 11, 2023, at 12:15 p.m. unlicensed personnel (ULP)-C was observed to administer R1's oral medications, complete a blood sugar check, and prepare R1's insulin pen for injection. R1's unnamed document, known as the R1's task record for August 2023, and September 2023, included various tasks for the unlicensed staff to complete, but lacked the description of when the tasks were to be completed (each shift, daily, weekly, or as needed). The tasks included: -assistance with dressing; -assistance with grooming;	0 730			

Minnesota Department of Health

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0 730	Continued From page 13 -assistance with bathing; -continence care; -assistance positioning; -assistance eating; -assistance walking; -assistance wheeling; -assistance transferring; -assistance with self-admin of meds; -verbal/visual med reminders; -delegated clinical monitoring; -other delegated tasks; -manage wandering; -manage orientation issues; -manage anxiety; -manage repetitive behavior; -manage agitation; -manage self-injurious behavior; -manage verbal aggression; -manage physical aggression; -manage property destruction; -meet other cognitive/mental need; -housekeeping/laundry; -assistance making appointments; -arrange non-medical services; -meal preparation; and -wound care (September task record) Additionally, the licensee failed to ensure R1's task record included consistent staff documentation when tasks were completed. On September 11, 2023, at 3:20 p.m. licensed assisted living director (LALD)-A stated he saw the missing staff initials as documentation of various tasks completed, and stated the areas defined as "delegated task" and initialed as completed did not describe what "delegated task" was performed. Additionally, LALD-A stated the task record lacked the description of when and how often each task was to be completed.	0 730			

Minnesota Department of Health

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0 730	Continued From page 14 LALD-A further stated the other residents' records would be the same. The licensee's Resident Record policy dated December 1, 2022, indicated contents of the resident record would include documentation that services have been provided as identified in the service plan. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
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 provide proper door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	0 800			

Minnesota Department of Health

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0 800	Continued From page 15 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 September 12, 2023, from approximately 9:30 a.m. to 10:30 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A. During the facility tour, survey staff observed and verified three emergency exit doors (front, side and basement), had dead bolts that required more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. 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			

Minnesota Department of Health

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0 810	Continued From page 16 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 a record review and interview, the licensee 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).	0 810		

Minnesota Department of Health

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0 810	Continued From page 17 Findings include: A record review and interview were conducted on September 13, 2023, between approximately 10:15 a.m. and 10:30 a.m., with Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not conduct employee evacuation drills twice per year per shift with at least one drill conducted every other month. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060			

Minnesota Department of Health

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01060	Continued From page 18 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060			

Minnesota Department of Health

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01060	Continued From page 19 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: R1 R1 was admitted to assisted living services on March 17, 2023. R1's Service Plan dated March 17, 2023, and R1's unsigned/undated, Service Plan Modification included the services of medication management, blood sugar checks, insulin draws, assistance with bathing, dressing, and toileting. R1's progress notes dated June 8, 2023, through June 12, 2023, indicated R1 was out of the facility visiting family; however, notes from June 13, 2023, through June 18, 2023, indicated R1 was then hospitalized and did not return to the facility until later June 18, 2023. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known;	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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01060	Continued From page 20 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On September 12, 2023, at 1: 25 p.m. licensed assisted living director (LALD)-A stated he was not aware of the requirement for relocation and notification of the Ombudsman. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620			

Minnesota Department of Health

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01620	Continued From page 21 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of one resident (R1) with a change of condition with a wound and unstable blood sugar levels and lacked complete content for a comprehensive assessment. 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1 was admitted to the facility under the facility's	01620		

Minnesota Department of Health

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01620	Continued From page 22 Assisted Living Facility (ALF) license on March 17, 2023. R1's Service Plan dated March 17, 2023, indicated she received services of medication assistance/administration, insulin draws, bathing, grooming, toileting assistance, housekeeping and mental health management. Additionally, R1's undated/unsigned, Service Plan Modification indicated she received the services of blood sugar checks three times daily and assistance with transfers. On September 12, 2023, at 8:30 a.m. unlicensed personnel (ULP-C) was observed to complete a dressing change and wound care to R1's lower left gluteal (buttock) area. The wound was located at the bottom of the left buttock and at the crease where the back thigh meets the buttock. It appeared concave and approximately the size of an adult hand, with an opening at the center (not measured) which was draining light yellow serous fluid. ULP-C stated R1 had a wound previously in the same area after a hospitalization in June, created a kind of "divot" but it had since healed. The wound had reappeared, was open and draining after R1 attended a full day at the state fair (August 29, 2023) and sat the entire time in a wheelchair. ULP-C stated the next day, R1 complained of her bottom hurting and staff found the wound had reappeared. Staff contacted R1's provider and R1 was sent to the emergency room for evaluation, a CT scan was completed and R1 was given antibiotics for a week. ULP-C stated a referral to R1's primary provider (September 13, 2023) and the wound clinic was also made. ULP-C stated the licensee's registered nurse has looked at the wound a few times each week since it reappeared and had provided written instruction (observed posted for ULP reference). ULP-C	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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01620	Continued From page 23 stated the RN had observed her and others complete wound care. On September 12, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated he had accompanied R1 to her emergency room visit on August 30, 2023, for evaluation of the wound. LALD-A stated he was given written orders for oral antibiotics and verbal orders for a simple wound dressing cleanse and dressing change to be done daily and as needed; furthermore, he was told a referral to the wound clinic was made, where further wound treatment would be directed. LALD-A stated since the redevelopment of the wound, and it's worsening appearance, he had accompanied R1 to her endocrinology appointment on September 5, 2023, and following that appointment took R1 to the wound clinic (found on the same floor of the clinic) to have R1 seen in the wound clinic sooner. LALD-A stated he was told R1 was a new patient and needed to wait until the set wound clinic appointment but to make sure R1 was seen by her primary care provider as scheduled, in the meantime. CHANGE IN CONDITION-WOUND R1's hospital discharge summary dated June 18, 2023, indicated a pressure injury, deep tissue Ischial tuberosity-left (left lower buttock area), and pressure injury deep tissue, thigh-left; upper posterior (back side of upper left thigh). R1's post hospital comprehensive assessment dated June 19, 2023, indicated for Integument (skin)-skin tear-left thigh-back-cover with dressing. The assessment lacked measurements or further description. R1's nurse's progress notes indicated the following entries: -June 29, 2023, "Resident have no complaining	01620			

Minnesota Department of Health

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01620	Continued From page 24 reports. She is sitting up okay and will so [sic] staff to help if she needs with ambulation with her walker. Wound looks better and healing, dry and intact. Looks a little bit green. Dressing changed daily and as needed. Denies pain, alert and oriented." -July 24, 2023, "Resident denies any concerns or issues, no pain reported. Her wound on the buttock which looks healing and no signs of infection. No other concerns noted or reported." -September 3, 2023, "Resident has wound that looks getting worse [sic]. Went to ER last week. She started antibiotic treatment and was referred to wound clinic. Daily dressing change and as needed until seen at the wound clinic. Also, she was dealing with hypoglycemia episodes [low blood sugars], working with her endo [endocrinologist, diabetes] provider and on call nurse/after hours nurse." R1's staff progress notes indicated the following entries related to her wound: -August 29, 2023, - [R1] attended the state fair with her partner. -August 30, 2023, - [R1] complained of pain from the wound. Staff contacted her medical team. Staff to take her to the emergency room to have it checked. -August 30. 2023, a.m. - [R1] went to the ER. She was not feeling good. -August 30, 2023, p.m.- [R1] is still at hospital. -August 31, 2023, overnight- [R1] returned from the hospital, had her meds [medications], meal and cares, slept well through the night. Overall, a good night's rest. -August 31, 2023, a.m. - [R1] had a good day. She ate both meals 100%. her BS [blood sugar] was checked and both insulin was given. Her wound was changed, and her laundry was done. R1 was sleeping on and off today.	01620			

Minnesota Department of Health

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01620	Continued From page 25 -September 4, 2023, a.m.- September 4, 2023, a.m.-[R1] had a great day. Her BS was 63 and orange juice, donuts and coffee were given. After one hour, rechecked again and was 89. RN and director were notified. They stated to call after hours nurse and I called them and explained about [R1]. Was told another nurse would call at 11:00 a.m., the after hours nurse spoke with [R1] about BS was low and asked me some information about [R1]'s BS and asked me to recheck BS again and I did, was 151, she told me to give her both insulins now. [R1] ate 100% of dinner. Her wound was changed, and it looks very bad, and the staff notified the nurse. Her bedding was changed. [R1] refused to walk all day today. Two Tylenol was given for pain. She currently watching TV in her room. -September 5, 2023, a.m.-[R1] looked very tired and she was very weak. She could barely walk. She went to her appointment with staff, but her wound is getting worse, and her BS was low. She ate lunch and took all her noon meds. R1's After Visit Summary from a regional hospital emergency room dated August 30, 2023, indicated the following note and treatment: -You were seen today for evaluation of a left gluteal wound. Your CT scan did not show signs of any deep space infection, however there is an ongoing local infection. We will give you some antibiotics to take with follow up with the wound care clinic as well as with your primary care doctor for further evaluation. -Start taking amoxicillin 500 milligram (mg) capsule by mouth three times a day for seven days for infection under the skin, and sulfamethoxazole-trimethoprim 800-160 mg by mouth two times a day for seven days for infection under the skin. -primary care physician set for September 13,	01620			

Minnesota Department of Health

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01620	Continued From page 26 2023. -wound clinic referral given. No wound measurements or description were documented by the ER provider. The licensee failed to complete a comprehensive assessment for a change in condition with the return of R1's lower left gluteal wound, evidence of infection, and failed to complete and document ongoing wound measurements or communication with providers. On September 13, 2023, at 9:30 a.m. clinical nurse supervisor (CNS)-B stated R1's lower left buttock wound started in June with a hospitalization and her skin was intact prior to that event. The licensee provided general maintenance of the wound at that time and the wound healed. CNS-B stated he documented this information. CNS-B stated R1 had attended a full day at the state fair with family on August 29, 2023, and had sat in a rented wheelchair all day. The next day on August 30, 2023, R1 had complained of her bottom hurting, staff observed her lower left buttock area and noted a large wound which was opened, draining and had a foul odor, and R1 was sent to the emergency room (ER) to have it further evaluated. R1 was sent home from the ER with oral antibiotics, simple wound cleansing and dressing change and a referral to the wound clinic for further management of the wound. The appointment was set for September. CNS-B stated he did not complete a full comprehensive assessment with the recurrence of the wound and stated he had observed it a couple times each week, wrote instructions for the wound care and ensured the ULP had completed the wound care appropriately. CNS-B stated he had pictures of the wound but had not completed measurements.	01620			

Minnesota Department of Health

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01620	Continued From page 27 CNS-B stated he lacked consistent documentation of each observation he made of R1's wound since it redeveloped. CHANGE IN CONDITION-LOW BLOOD SUGARS R1's progress notes indicated the following entries associated with changes in R1's blood sugars and weakness: -August 31, 2023, p.m.-[R1] is doing better today, her blood sugar was low. She ate and took all her night meds [medications] and went to bed. -September 1, 2023, 12:00 a.m.-8:00 a.m.- [R1] blood sugar was checked at 4:38 a.m. and levels were within normal acceptable range (85). She reported sleeping well, expressed feeling good, und and watching TV. No concern. -September 1, 2023, 8:00 a.m.-4:00 p.m.- [R1]'s day pretty much okay. Her BS [blood sugar] at 6:00 a.m. was low. Staff treated it with orange juice, toast with jam and banana. She also had coffee. Per RN both insulins were on hold. Staff checked her BS at 7:45 a.m. this time it's 256-contacted her Endocrinology clinic regarding her low blood sugar. Lantus was administered per [R1's] Endocrinologist. After they review [R1]'s most recent BS data, [provider] recommended to lower Lantus and Novolog doses. Lantus from 43 units at breakfast to 40 units at breakfast. Novolog from nine units to eight units base and +one unit per 50 points [blood sugar reading]. All cares, meals and meds were given. No concerns. -September 1, 2023, 4:00 p.m.-12:00 a.m.- [R1] had pretty good evening, her BS up and down all day, meds, meal, and care provided. Up late watching TV, now relaxing. -September 2, 2023, 8:00 a.m.- 4:00 p.m.- [R1] blood sugar within range, meds, meals, and wound care provided. She expressed discomfort (sic) and RN contacted.	01620			

Minnesota Department of Health

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01620	Continued From page 28 -September 2, 2023, 4:00 p.m.-12:00 a.m.- [R1] seemed to have an okay evening, she's tired, she stayed on her bed all evening, staff checked her BS a few times, it's 73 at supper time, 83 after two hours. [Provider] nurse line was contacted for instruction. The nurse suggested to feed [R1] to increase her BS-staff gave her some food, [R1] had difficulty drinking orange juice due to sleeping med. She was tired. Again, staff took her BS, it's 116. Lastly, it's taken at 12:00 a.m., it's 104. Per the nurse [R1]'s Lantus will be 40 units and Novolog five units +one unit per 50 points [blood sugar] effective tomorrow. [R1 has an appointment with her Endocrinologist on Tuesday September 5. -September 3, 2023, 12:00 a.m.-4:00 p.m.- [R1] had a good night sleep but struggled once is up. Her legs gave in and slid down to the floor. -September 3, 2023, 4:00 p.m.-12:00 a.m. [R1]'s evening has been okay. She stayed in her room and staff helped her to go to and from the bathroom. Cares, meals, and meds were given. Staff took her BS at 4:20 p.m. it's 106, at 5:50 p.m. it's 107, gave her food/supper. Checked her BS at 10:46 p.m. is 61. Gave snacks to drink and took her BS at 11:06 p.m. it's 81. Will try giving her some food. (she's very sleepy). The overnight staff will monitor her BS. -September 4, 2023, night- [R1] slept well last night, her BS around 5:00 a.m. was 126, after letting her sleep a little more at 8:00 a.m. it was checked again and dropped to 63, gave her coffee, meds, and breakfast. -September 4, 2023, a.m.-[R1] had a great day. Her BS was 63 and orange juice, donuts and coffee were given. After one hour, rechecked again and was 89. RN and director were notified. They stated to call after hours nurse and I called them and explained about [R1]. Was told another nurse would call at 11:00 a.m., the after hours	01620			

Minnesota Department of Health

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01620	Continued From page 29 nurse spoke with [R1] about BS was low and asked me some information about [R1]'s BS and asked me to recheck BS again and I did, was 151, she told me to give her both insulins now. [R1] ate 100% of dinner. Her wound was changed, and it looks very bad, and the staff notified the nurse. Her bedding was changed. [R1] refused to walk all day today. Two Tylenol was given for pain. She currently watching TV in her room. -September 4, 2023, p.m. (evening)- [R1] is doing a little bit better today. Her blood sugar was low, but she had dinner, took all her night meds. Still concern about her BS. -September 5, 2023, 12:00 a.m.-9:00 a.m.-[R1]'s night has been good. Staff checked her BS a couple of times and provided food. This morning her BS was checked, it's 128 at 6:15 a.m. [R1] refused to eat breakfast, only had two cups of coffee. Then at 8:55 a.m., BS was taken was 146. Both insulin and breakfast were given. Other services were given also. no concerns. -September 5, 2023, a.m.- [R1] looked very tired and she was very weak. She could barely walk. She went to her appointment with staff, but her wound is getting worse, and her BS was low. She ate lunch and took all her noon meds. -September 5, 2023, p.m. (evening)- [R1] evening was pretty good. She had dinner, BS checked, wound checked, med delivered as prescribed. no concerns. -September 6, 2023, 12:00 a.m.-8:00 a.m.- [R1]'s night has been pretty good. Staff checked her BS at midnight and provided her food. She slept well. Refused breakfast but had coffee (two-three) cups. A.M. meds provided; other cares also given. A review of R1's September 2023, medication administration record (MAR) which included R1's	01620			

Minnesota Department of Health

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01620	Continued From page 30 blood sugar readings and indicated several instances of low blood sugars, which resulted in contact with the RN and provider. The dates and readings indicated: -September 1, 2023,-64 two hours after breakfast; -September 2, 2023,- 49 before breakfast; -September 3, 2023,-70 at breakfast, 55 at lunch, 61 at "night", 70 at 5:35 a.m. -September 4, 2023, -63 at breakfast -September 7, 2023, -54 at breakfast R1's After Visit Summary (Endocrinology) dated September 5, 2023, included the following changes in insulin dosing: -Insulin glargine 100 units/ml (milliliter), inject 35 units subcutaneously (into the skin) every morning; -decrease Novolog to four units before meals -decrease Novolog correction scale to one unit insulin per 50 over 200 (see table) for blood sugar: 70-200 give four units insulin 201-250 give five units insulin 251-300 give six units insulin 301-350 give seven units insulin 351 and over give eight units insulin On September 13, 2023, at 9:35 a.m. CNS-B stated staff had notified him of R1's low blood sugars over the course of the changes of R1's buttocks wound. He had given direction to the ULP for the low blood sugars and had follow up communication with R1's provider but had not completed a comprehensive assessment with the unstable blood sugars, increased weakness, and changes in insulin dosing. ASSESSMENT CONTENT R1's comprehensive assessments dated March	01620			

Minnesota Department of Health

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01620	Continued From page 31 17, 2023 (admission), March 30, 2023, (14 day), and June 19, 2023, (change in condition), lacked vital signs, weight, and a review of blood sugar readings. On September 13, 2023, at 9:35 a.m. CNS-B stated the above assessments completed, lacked complete information regarding vital signs, weight, and blood sugar reviews. The licensee's Nursing Assessment and Reassessment policy dated December 1, 2022, indicated a comprehensive assessment would be conducted by a registered nurse pre-admission, completed within 14 days after start of services, with change in condition and at least every 90 days. The comprehensive assessment/reassessment would include a review of: Weight and vital signs and evaluation of any treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640			

Minnesota Department of Health

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01640	Continued From page 32 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1) and lacked a date and signature by the resident or resident's representative. 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: R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 17, 2023. R1's diagnoses included type two diabetes (when the body no longer manages insulin production	01640			

Minnesota Department of Health

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01640	Continued From page 33 and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received services of medication assistance/administration, insulin draws, bathing, grooming, toileting assistance, housekeeping and mental health management. Additionally, R1's undated/unsigned, Service Plan Modification indicated she received the services of blood sugar checks three times daily and assistance with transfers. R1's progress note dated August 30, 2023, indicated R1 complained of pain from a wound on her buttock area. Staff contacted her medical team and staff took her to the emergency room for further evaluation. R1's After Visit summary dated August 30, 2023, read "You were seen for evaluation of a left gluteal wound. Your CT scan did not show any signs of any deep space infection, however there is an ongoing local infection. We will give you some antibiotics to take with follow up with the wound care clinic as with your primary care doctor for further evaluation." R1's unnamed document, known as the licensee's task record, dated September 2023, indicated "wound care" with staff initials entered for the dates of September 2, 3, 4, 5, 6,7, 8, 10, 2023. On September 12, 2023, at 8:30 a.m. unlicensed personnel (ULP)-C was observed to complete wound care to R1's lower buttock wound. ULP-C stated they completed wound care twice daily and as needed if the dressing came off or was soiled.	01640			

Minnesota Department of Health

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01640	Continued From page 34 On September 12, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated he accompanied R1 to the emergency room on August 23, 2023, and received written orders for a seven-day course of antibiotics. LALD-A stated he received verbal instruction for wound care and some wound supplies until R1 was seen by the wound clinic. The instruction for wound care included cleansing with a wound cleanser and covering the wound with an absorbent dressing daily and as needed. R1's Service Plan lacked the service of wound care. Additionally, the document named Service Plan Modification, was signed only by the registered nurse and lacked a date and signature by R1 or a representative. On September 13, 2023, at 9:20 a.m. clinical nurse supervisor (CNS)-B stated R1's wound had just changed two weeks ago, and he had not added the wound care to the service plan. CNS-B stated, "She [R1] knows the services we do." Additionally, CNS-B stated he had not ensured R1 signed and dated the Service Plan Modification when that was completed. The licensee's Service Plan policy dated December 1, 2022, indicated the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. The service plan must be revised as needed based on resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
NAME OF PROVIDER OR SUPPLIER HIGHVIEW HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1460 FARRINGTON STREET SAINT PAUL, MN 55117			
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01640	Continued From page 35 (21) days	01640			
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 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 observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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01650	Continued From page 36 resident (R1). 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: R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 17, 2023. R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related) convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received services of medication assistance/administration, insulin draws, bathing, grooming, toileting assistance, housekeeping and mental health management. Additionally, R1's undated/unsigned, Service Plan Modification indicated she received the services of blood sugar checks three times daily and assistance with transfers. On September 12, 2023, at 8:15 a.m. unlicensed personnel (ULP)-C was observed to administer R1's oral medications, complete a blood sugar check, and prepare and assist with R1's insulin pen injection, and at 8:30 a.m., ULP-C was observed to complete wound care for R1's lower left buttock wound.	01650			

Minnesota Department of Health

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01650	Continued From page 37 R1's unnamed document, known as the licensee's task record, dated September 2023, indicated "wound care" with staff initials entered for the dates of September 2, 3, 4, 5, 6,7, 8, 10, 2023. R1's Service Plan lacked the required content of: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (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. On September 12, 2023, at 10:45 a.m. licensed assisted living director (LALD)-A stated R1's fees are managed by the county, and he had a county rate sheet. LALD-A stated he did not attach a rate	01650			

Minnesota Department of Health

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01650	Continued From page 38 sheet to the Service Plan. Furthermore, LALD-A stated he was not aware of the required content for the Service Plans and stated R1's Service Plan and other residents in the facility lacked the required content. On September 13, 2023, at 9:30 a.m. clinical nurse supervisor (CNS)-B stated R1's wound care had just started two weeks before and he had not updated the service plan to include the wound care; furthermore, R1's Service Plan lacked the fees, frequency and staff who would complete the service of wound care. The licensee's Service Plan policy dated December 1, 2022, indicated the service plan would include: -A description of the services to be provided -The staff or categories of staff that will provide the services -The type and frequency of visits/services proposed to be furnished according to the resident's current review/assessment and resident preferences -The fees for services -The schedule and methods of monitoring assessments of the resident -The schedule and methods of monitoring staff providing services -The extent to which payment may be expected from a third-party payer -The charges for services that will not be covered by a third-party payer -The charges the individual may have to pay -A contingency plan for circumstances when services cannot be provided 5. Plan for contingency action shall include: a. The action to be taken by the provider if scheduled services cannot be provided b. Information and a method for a resident or	01650			

Minnesota Department of Health

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01650	Continued From page 39 their representative to contact the facility c. Name and contact information of persons the resident wished to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification and information as to who has authority to sign for the resident in an emergency d. 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. 6. A medical emergency plan is established which identifies any advance directives the resident might have made as well as code status. The Service Plan shall be signed by the resident or financially responsible party. 8. The resident shall be advised, orally and in writing, of any changes in type or frequency of services or fee schedule. This advisement shall occur as soon as possible after the facility becomes aware of the change. Written notice will be given by making the appropriate changes on the Service Plan and obtaining resident/representative signature or initials. 9. The original Service Plan and any revised service plan must be entered into the resident record, including notice of a change in fees when applicable. 10. Changes in types of services or fees will be based on assessment of the resident or resident preferences and reviewed with the resident/representative and noted on the Service Plan, as appropriate. All changes in the Service Plan must be acknowledged by the resident. No further information was provided. TIME PERIOD FOR CORRECTION:	01650			

Minnesota Department of Health

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01650	Continued From page 40 Twenty-One (21) days.	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include	01700			

Minnesota Department of Health

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01700	Continued From page 41 all required content for one of one resident (R1) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 11, 2023, at 11:30 a.m. licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to all the residents receiving assisted living services. R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on March 17, 2023. R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the service of medication administration. On September 12, 2023, at 8:15 a.m. unlicensed personnel (ULP)-C administered R1's oral medications and set up/prepared R1's glargine insulin pen for R1's self-administration.	01700			

Minnesota Department of Health

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01700	Continued From page 42 R1's Medication Administration Record (MAR) dated September 2023, included one medication for high blood pressure, two supplements, one blood thinner, one oral medication for diabetes, one for seizures, one for nerve pain, two insulin injectable medications, one for agitation, one for high cholesterol, one for sleep, and one oral pain medication and one topical cream (on the skin) for mild pain. R1's Medication Assessment dated March 17, 2023, lacked evidence the assessment was conducted face-to-face with the resident. The assessment lacked an identification and review of all medications the resident is known to be taking, to include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Furthermore, the assessment failed to identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated he believed a previous MAR included the indications for medications, and he was not familiar with all the required content of a medication assessment. Additionally, CNS-B stated the other residents medication assessments would have similar content. The licensee's Nursing Assessment and Reassessment policy dated December 1, 2022, indicated the assessment for medication	01700			

Minnesota Department of Health

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01700	Continued From page 43 management must be face to face with the resident and must include identifying all medications and indications for them, potential side effects and contraindications, adverse reactions and how to address those issues, and interventions to prevent diversion of the medications by the resident or by others who have access to the medications. Diversion includes misuse, theft or illegal or improper disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730			

Minnesota Department of Health

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01730	Continued From page 44 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan was revised and included all the required content for one of one resident (R1). 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:	01730			

Minnesota Department of Health

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01730	Continued From page 45 R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the service of medication administration and insulin pen management. On September 11, 2023, at 12:15 p.m. unlicensed personnel (ULP)-C was observed to set up and administer one oral medication and prepared R1's glargine insulin pen for administration. ULP-C stated the staff prepare the insulin pen by attaching a new needle, priming the pen (clearing the needle from air), dialing the pen to the proper dose dependent on her insulin sliding scale (adjusting the dose of insulin depending on R1's blood sugar level) and helped cleanse R1's skin prior to R1 self-administering the insulin. ULP-C stated the registered nurse (RN) has told the staff to hold R1's insulin when she does not wish to eat. ULP-C stated the staff set up and administer R1's medications as R1 has changed over the past few months and does not always remember her medications. R1's Medication Administration Record (MAR) dated September 2023, included one medication for high blood pressure, two supplements, one blood thinner, one oral medication for diabetes, one for seizures, one for nerve pain, two insulin injectable medications, one for agitation, one for high cholesterol, one for sleep, and one oral pain medication and one topical cream (on the skin) for mild pain. R1's provider orders last revised/dated	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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01730	Continued From page 46 September 5, 2023, indicated the following insulin orders: -Glargine (long-acting insulin) insulin-35 units subcutaneously (under the skin) every morning -Novolog (short acting) flex pen 100 units/milliliter (u/ml)-inject 4 units subcutaneously three times daily before meals. Plus, correction scale of 1 unit per 50>200 (based on blood sugar level prior to each meal): 70-200 give four units insulin 201-250 give five units insulin 251-300 give six units insulin 301-350 give seven units insulin 351 and over give eight units insulin R1's MAR dated August 2023, included a staff note when R1 had refused a meal and her Novolog (short acting) insulin was held; the dates included: August 1, 2, 3, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 27, 29, 30, 2023. R1's MAR dated September 2023, included a staff note when R1 had refused a meal and her Novolog insulin was held; the dates included: September 1, 2, 4, 2023. On September 11, 2023, at 12:15 p.m. ULP-C stated she was not aware of any written directions regarding insulin from the nurse when R1 refused meals and stated, "we just call the nurse." R1's record lacked direction from the registered nurse (RN) when to hold R1's insulin when she refused meals. R1's Medication Assessment/Delegation Form dated March 17, 2023, indicated resident was independent in medication management, the pharmacy did medication set up, the nurse would check when medications are delivered as needed	01730			

Minnesota Department of Health

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01730	Continued From page 47 and monthly. On another line the document indicated R1 required the aide to assist with medications daily. The document indicated the resident required insulin administration daily and used a sliding scale, and indicated medications must be locked up. The licensee failed to update R1's medication management record to identify staff were managing medication administration and R1 was no longer independent with medication management. R1's Medication Assessment/Delegation Form also lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated he was working with R1's Endocrinologist (a provider who manages diabetes and related medications) to obtain more definitive direction for R1's blood sugars and insulin dosing. CNS-B stated he has	01730			

Minnesota Department of Health

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01730	Continued From page 48 some information posted for staff about when R1's blood sugar is high but not specifics of when R1 is not eating stating, "the staff just call me." Additionally, CNS-B stated the Medication Assessment/Delegation form was what he used for a medication plan for each of the residents and stated he was not familiar with what the required content was. The licensee's Individualized Medication Management Plan and Record policy dated December 1, 2022, indicated the plan must include: a. A statement describing the medication management services that will be provided b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. The RN asks the resident and/or the resident's representative to sign the Individualized Medication Management plan when the service	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/13/2023
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01730	Continued From page 49 plan is signed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were clarified and transcribed correctly per physician order for one of one resident (R1). 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	01760			

Minnesota Department of Health

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01760	Continued From page 50 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the service of medication administration and insulin pen management. On September 11, 2023, at 12:15 p.m. unlicensed personnel (ULP)-C was observed to conduct a blood sugar check, set up and administered one oral medication and prepared R1's Novolog insulin pen for administration. ULP-C was observed to attach a new needle, prime the insulin pen (clearing the needle from air), referenced the posted insulin sliding scale (insulin dosing associated with blood sugar level), dialed the pen to the proper dose and helped cleanse R1's abdominal skin. R1 was observed to self-administer the insulin. ULP-C then documented her initials on R1's paper medication administration record (MAR) in the sections associated with the medications administered. ULP-C stated the staff only document their initials and do not indicate how much insulin was administered. ULP-C added, there was not a designated spot on the MAR to document which site the insulin was given. R1's MAR dated September 2023, included one medication for high blood pressure, two supplements, one blood thinner, one oral	01760			

Minnesota Department of Health

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01760	Continued From page 51 medication for diabetes, one for seizures, one for nerve pain, two insulin injectable medications, one for agitation, one for high cholesterol, one for sleep, and one oral pain medication and one topical cream (on the skin) for mild pain. INSULIN DOSING R1's provider orders last revised/dated September 5, 2023, indicated the following insulin orders: -Glargine (long-acting insulin) insulin-35 units subcutaneously (under the skin) every morning; a verbal order was taken later September 5, 2023, to again decrease glargine to 20 units daily; and -Novolog (short acting) flex pen 100 units/milliliter (U/ml)-inject 4 units subcutaneously three times daily before meals. Plus, correction scale of 1 unit per 50>200 (based on blood sugar level prior to each meal): 70-200 give four units insulin 201-250 give five units insulin 251-300 give six units insulin 301-350 give seven units insulin 351 and over give eight units insulin R1's MAR dated September 2023, included insulin aspart (Novolog) 100 units/milliliter (U/ml), inject 8 units (was crossed out) and handwritten addition indicated 4 units eff [effective] September 5, 2023, prior to meals three times per day. The dates initialed by staff included: -8:00 a.m. September 2, 3, 5, 11, 2023; -12:00 p.m. September 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 2023; -5:00 p.m. September 2, 3, 4, 5, 6, 7, 8, 9, 10, 2023. Additionally, the MAR included glargine insulin 100 U/ml inject 40 units (crossed out) with handwritten 20 units eff [effective] September 5, 2023, under the skin every morning. The dates	01760			

Minnesota Department of Health

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01760	Continued From page 52 initialed by staff included September 1-11, 2023, at 8:00 a.m. R1's MAR lacked a clear indication of what Novolog insulin dose was given and if adjusted by her insulin sliding scale, lacked clear documentation with a change in the starting base dose of Novolog insulin from 8 units to 4 units as well as the dose change associated with glargine; furthermore, the MAR lacked an indication of the site where the insulin was injected for both glargine and Novolog insulins. ROUTES OF ADMINISTRATION R1's MAR dated September 2023, lacked the route of administration and indication for the following medications: -lisinopril 5 milligram (mg), one tablet-8:00 a.m. (for high blood pressure) -Vitamin B1 100 mg- 8:00 a.m.(supplement) -aspirin 81 mg chew-8:00 a.m. (for the heart) -Metformin 500 mg 8:00 a.m., 5:00 p.m. (oral agent for diabetes) -levetiracetam 500 mg, 8:00 a.m., 8:00 p.m. (for seizures) -Gabapentin 600 mg, two tablets, 8:00 a.m., 12:00 p.m., 8:00 p.m. (for nerve pain) -quetiapine 300 mg, two tablets, 8:00 p.m. -atorvastatin 40 mg, one tablet, 8:00 p.m. AS NEEDED MEDICATIONS R1's provider orders dated September 5, 2023, indicated acetaminophen 500 milligrams (mg), two tablets every six hours as needed. Additionally, the record included an order for Ambien 10 mg, one tablet each night as needed for sleep. On September 11, 2023, at 1:00 p.m. the surveyor reviewed R1's September 2023, MAR	01760			

Minnesota Department of Health

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01760	Continued From page 53 and any follow up documentation for scheduled and as needed (PRN) medications given. The record indicated acetaminophen 500 mg, give two tablets every six hours as needed and indicated R1 received acetaminophen on September 4, 6, 9, 2023, for pain, and Ambien on September 10, 2023; however, the record lacked any indication of effectiveness of the as needed medications. On September 11, 2023, at 3:20 p.m. licensed assisted living director (LALD)-A stated there was not a clear distinction of how many units of insulin was given when using R1's sliding scale. LALD A stated, "I see that it unclear and there have been several changes in the past two weeks with her [R1's] insulin and we have just crossed out the previous date and wrote a new "effective date, when a change occurred." Additionally, LALD-A stated the staff sometimes wrote the follow up to an as needed medication in the resident's progress notes; however, with review of R1's progress notes for the dates indicated when an as needed medication was given, no other follow up notes were found. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated he thought R1's previous MARs had the required content and must have missed editing the MAR recently. CNS-B stated he expected the ULP to write a follow up note after a PRN medication was given. The licensee's Documentation of Medication Administration policy dated December 1, 2022, indicated each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date, and	01760			

Minnesota Department of Health

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01760	Continued From page 54 time administered, and method and route of administration. Staff will 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. Novolog manufacturer's instructions dated January 2019, indicated injection sites should be rotated between four injection spots. Glargine manufacturer's instructions dated 2022, indicated change (rotate) your injection sites within the area you chose with each dose to reduce the risk of getting pitted or thickened skin. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of one resident (R1).	01820			

Minnesota Department of Health

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01820	Continued From page 55 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: R1's Service Plan dated March 17, 2023, indicated she received the service of medication administration and insulin pen management. On September 12, 2023, at 8:15 a.m. unlicensed personnel (ULP)-C was observed to prepare R1's glargine insulin pen and set the dose for 20 units and handed the insulin pen to R1 who then self-administered into her lower left abdomen. R1's Medication administration record (MAR) dated September 2023, indicated glargine insulin 100 units/milliliter (U/ml), inject 40 units (was crossed out) with 20 units written by hand, eff [effective] September 5, 2023. R1's provider orders dated September 5, 2023, indicated a new order for glargine (long-acting insulin) insulin, 35 units subcutaneously (under the skin) every morning. On September 12, 2023, at 1:00 p.m. licensed assisted living director (LALD)-A stated over the course of the past couple of weeks, R1 had some low blood sugar levels, had an endocrinology (diabetes provider) appointment with some insulin dose changes. He stated after the glargine orders were provided in writing, the provider's nurse	01820			

Minnesota Department of Health

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01820	Continued From page 56 called and again adjusted the glargine dose from 35 units to 20 units daily. LALD-A stated he took the order, let the clinical nurse supervisor (CNS)-B know and there was not a request for a written order made by the licensee. R1's record lacked a signed prescriber's order for the glargine dosing change. On September 13, 2023, at 10:45 a.m. CNS-B stated he was not aware an unlicensed staff could not take a verbal order from a registered nurse, and thought it only pertained to taking an order from a physician. The licensee's Medication Prescriptions and Refills policy dated December 1, 2022, indicated A current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. Upon receiving verbal orders, the RN or LPN will record and sign the verbal order and forward the order to the prescriber for a signature. The RN or LPN will continue to follow up with the prescriber's office or the pharmacy until a signed prescription/ verbal order is received and will document all efforts to obtain a signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01840 SS=D	144G.71 Subd. 15 Verbal prescription orders Verbal prescription orders from an authorized	01840			

Minnesota Department of Health

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01840	Continued From page 57 prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure verbal prescription orders from an authorized prescriber were received by a nurse or pharmacist for one of one resident (R1). 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the service of medication administration and insulin pen management. R1's Service Plan lacked the service of wound care. INSULIN ORDER On September 12, 2023, at 8:15 a.m. unlicensed personnel (ULP)-C was observed to prepare R1's glargine insulin pen and set the dose for 20 units and handed the insulin pen to R1 who then	01840			

Minnesota Department of Health

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01840	Continued From page 58 self-administered into her lower left abdomen. R1's Medication administration record (MAR) dated September 2023, indicated glargine insulin 100 units/milliliter (U/ml), inject 40 units (was crossed out) with 20 units written by hand, eff [effective] September 5, 2023. R1's provider orders dated September 5, 2023, indicated a new order for glargine (long-acting insulin) insulin, 35 units subcutaneously (under the skin) every morning. On September 12, 2023, at 1:00 p.m. licensed assisted living director (LALD)-A stated over the course of the past couple of weeks, R1 had some low blood sugar levels, had an endocrinology (diabetes provider) appointment with some insulin dose changes. He stated after the glargine orders were provided in writing, the provider's nurse called and again adjusted the glargine dose from 35 units to 20 units daily. LALD-A stated he took the order, let the clinical nurse supervisor (CNS)-B know and there was not a request for a written order made by the licensee. WOUND CARE ORDERS On September 12, 2023, at 8:30 a.m. ULP-C was observed to complete wound care for R1's lower left buttock wound. ULP-C stated the wound had previously healed but had reappeared after R1 spent a full day at the state fair sitting in a wheelchair. ULP-C stated R1 was seen in the emergency room for evaluation and care instructions of the wound with a referral to the wound clinic for further care. ULP-C stated CNS-B had written instructions for staff to follow and had observed wound care being completed. On September 13, 2023, at 9:00 a.m. LALD-A	01840			

Minnesota Department of Health

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01840	Continued From page 59 stated he accompanied R1 to the emergency room for evaluation of R1's lower left buttock wound on August 30, 2023. LALD-A stated he received verbal instructions for wound care and was given some wound care supplies until R1 could be seen in the wound clinic for further evaluation and treatment. LALD-A stated he did not receive any written orders for wound care from the emergency room provider and did not understand he needed written orders. On September 13, 2023, at 10:45 a.m. CNS-B stated he was not aware an unlicensed staff could not take a verbal order from a registered nurse, and thought it only pertained to taking an order from a physician. The licensee's Medication Prescriptions and Refills policy dated December 1, 2022, indicated upon receiving verbal orders, the RN or LPN will record and sign the verbal order and forward the order to the prescriber for a signature. The RN or LPN will continue to follow up with the prescriber's office or the pharmacy until a signed prescription/ verbal order is received and will document all efforts to obtain a signature. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01840			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940			

Minnesota Department of Health

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01940	Continued From page 60 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 (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 an individualized treatment management plan to include all required content for one of one resident (R1). 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	01940			

Minnesota Department of Health

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01940	Continued From page 61 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the services of blood sugar checks, medication administration and insulin pen management. R1's Service Plan lacked the service of wound care. BLOOD SUGAR CHECKS On September 11, 2023, at 12:15 p.m. unlicensed personnel (ULP)-C was observed to conduct a blood sugar check, set up and administered one oral medication and prepared R1's Novolog insulin pen for administration. ULP-C stated she "just knew when to alert the nurse about low or high blood sugars." She added, "I thought we had it written somewhere. I cannot find it though." R1's provider orders dated September 5, 2023, indicated blood sugar checks to be completed three times daily. Additional instructions read, contact the provider's office for blood sugar readings less than 70 more than twice in one week or if multiple blood sugar readings more than 200. A review of R1's September 2023, medication administration record (MAR) which included R1's	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2023
NAME OF PROVIDER OR SUPPLIER HIGHVIEW HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1460 FARRINGTON STREET SAINT PAUL, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 62 blood sugar readings and indicated several instances of low blood sugars, resulting in contacting the registered nurse and provider. The dates and readings indicated: -September 1, 2023, - 64 two hours after breakfast; -September 2, 2023, - 49 before breakfast; -September 3, 2023, - 70 at breakfast, 55 at lunch, 61 at "night", 70 at 5:35 a.m. -September 4, 2023, - 63 at breakfast -September 7, 2023, - 54 at breakfast WOUND CARE On September 12, 2023, at 8:30 a.m. ULP-C was observed to provide wound care to R1. ULP-C removed a previous dressing, cleansed the wound with spray cleanser and gauze, and covered the wound with a clean adhesive edged dressing. ULP-C stated the licensee completed a dressing change twice daily and as needed if the dressing came off or was soiled. On September 12, 2023, at 8:45 a.m. the surveyor observed an undated set of instructions for R1's wound care. The instructions included general steps and when to contact the nurse, but lacked specific supplies used for R1's dressing change and wound care. On September 12, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated he accompanied R1 to the emergency room on August 23, 2023, and received written orders for a seven-day course of antibiotics. LALD-A stated he received verbal instruction for wound care and some wound supplies until R1 was seen by the wound clinic. The instruction for wound care included cleansing with a wound cleanser and covering the wound with an absorbent dressing daily and as needed.	01940			

Minnesota Department of Health

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01940	Continued From page 63 R1's After Visit summary dated August 30, 2023, read "You were seen for evaluation of a left gluteal wound. Your CT scan did not show any signs of any deep space infection, however there is an ongoing local infection. We will give you some antibiotics to take with follow up with the wound care clinic as with your primary care doctor for further evaluation." R1's unnamed document, known as the licensee's task record, dated September 2023, indicated "wound care" with staff initials entered for the dates of September 2, 3, 4, 5, 6, 7, 8, 10, 2023. R1's Individualized Treatment or Therapy Management Plan dated March 12, 2023, included blood sugar monitoring, but lacked blood sugar parameters for when ULP should contact the nurse, and lacked the treatment of wound care and the required content of a Treatment Plan to include: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	01940			

Minnesota Department of Health

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01940	Continued From page 64 treatment or therapy management record must be current and updated when there are any changes. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated staff called him when R1 had low blood sugars, but nothing had been formally written. Additionally, CNS-B stated he would need update the treatment plan to include the wound care, and stated, "the wound care just started recently." The licensee's Treatment and Therapy Plan policy dated December 1, 2022, indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided. b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services. e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01940		

Minnesota Department of Health

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01960	Continued From page 65	01960			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of one resident (R1). 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures).	01960			

Minnesota Department of Health

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01960	Continued From page 66 R1's Service Plan dated March 17, 2023, indicated she received the services of blood sugar checks, medication administration and insulin pen management. R1's Service Plan lacked the service of wound care. On September 12, 2023, at 8:30 a.m. ULP-C was observed to provide wound care to R1. ULP-C removed a previous dressing, cleansed the wound with spray cleanser and gauze, and covered the wound with a clean adhesive edged dressing. ULP-C stated the licensee completed a dressing change twice daily and as needed if the dressing came off or was soiled. On September 12, 2023, at 8:45 a.m. the surveyor observed an undated set of instructions for R1's wound care. The instructions included general steps and when to contact the nurse, but lacked specific supplies used for R1's dressing change and wound care. On September 12, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated he accompanied R1 to the emergency room on August 23, 2023, and received written orders for a seven-day course of antibiotics. LALD-A stated he received verbal instruction for wound care and some wound supplies until R1 was seen by the wound clinic. The instruction for wound care included cleansing with a wound cleanser and covering the wound with an absorbent dressing daily and as needed. R1's After Visit summary dated August 30, 2023, read "You were seen for evaluation of a left gluteal wound. Your CT scan did not show any signs of any deep space infection, however there is an ongoing local infection. We will give you some antibiotics to take with follow up with the	01960			

Minnesota Department of Health

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01960	Continued From page 67 wound care clinic as with your primary care doctor for further evaluation." R1's unnamed document, known as the licensee's task record, dated September 2023, indicated "wound care" with staff initials entered for the dates of September 2, 3, 4, 5, 6, 7, 8, 10, 2023. The task record lacked specific direction and the times R1's wound care was assigned to be completed. The task record also lacked staff initials for the treatment of wound care on September 1, 2023, and September 9, 2023. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated he had not received further direction on R1's wound care and was waiting for the wound clinic appointment to create more detail. The licensee's Treatment and Therapy Plan policy dated December 1, 2022, indicated each task (therapy or treatment) will be documented in the resident record. Each entry will include the signature and title of the person who administered the treatment and will include the date and time of administration. Additionally, when the treatment or therapy is not administered as ordered, the facility will document the reason why it was not administered, communicate with prescriber as needed, and any follow up procedures that were provided to meet the resident need. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970			

Minnesota Department of Health

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01970	Continued From page 68 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 observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's diagnoses included type two diabetes (when the body no longer manages insulin production and blood sugar levels), long term use of insulin, chronic kidney disease, depression, and complex febrile (fever related), convulsions (seizures). R1's Service Plan dated March 17, 2023, indicated she received the services of blood sugar checks, medication administration and insulin pen management. R1's Service Plan	01970			

Minnesota Department of Health

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01970	Continued From page 69 lacked the service of wound care. On September 12, 2023, at 8:30 a.m. ULP-C was observed to provide wound care to R1. ULP-C removed a previous dressing, cleansed the wound with spray cleanser and gauze, and covered the wound with a clean adhesive edged dressing. ULP-C stated the licensee completed a dressing change twice daily and as needed if the dressing came off or was soiled. On September 12, 2023, at 8:45 a.m. the surveyor observed an undated set of instructions for R1's wound care. The instructions included general steps and when to contact the nurse, but lacked specific supplies used for R1's dressing change and wound care. R1's After Visit summary dated August 30, 2023, read "You were seen for evaluation of a left gluteal wound. Your CT scan did not show any signs of any deep space infection, however there is an ongoing local infection. We will give you some antibiotics to take with follow up with the wound care clinic as with your primary care doctor for further evaluation." R1's unnamed document, known as the licensee's task record, dated September 2023, indicated "wound care" with staff initials entered for the dates of September 2, 3, 4, 5, 6, 7, 8, 10, 2023. The task record lacked specific direction and the times R1's wound care was assigned to be completed. The task record also indicated missing staff initials for the treatment of wound care on September 1, 2023, and September 9, 2023. On September 12, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated he	01970			

Minnesota Department of Health

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01970	Continued From page 70 accompanied R1 to the emergency room on August 23, 2023, and received written orders for a seven-day course of antibiotics. LALD-A stated he received verbal instruction for wound care and some wound supplies until R1 was seen by the wound clinic. The instruction for wound care included cleansing with a wound cleanser and covering the wound with an absorbent dressing daily and as needed. LALD-A stated he did not receive written orders/instructions from the emergency room. On September 13, 2023, at 10:45 a.m. clinical nurse supervisor (CNS)-B stated he had not reached out to a provider for written instructions/orders and was waiting for further direction from the wound clinic. The licensee's Treatment and Therapy Management Plan policy dated December 1, 2022, indicated when the nurse/therapist received a verbal order from the physician/authorized prescriber, he/she shall immediately record and sign the telephone order form and obtain the prescriber's countersignature. It is the facility's responsibility to send telephone orders to the physician or authorized prescriber for signature as soon as possible after receipt of the verbal order. A system will be used by the facility to ensure that the telephone orders are signed and dated by the physician/prescriber and returned to the resident's clinical record within an appropriate time frame. The Nurse/Therapist shall document implementation of order changes and instructions given and all physician/prescriber orders shall be maintained in the clinical record. The order must contain the name of the resident, a description of the treatment or therapy and frequency and any other information needed to administer the treatment or therapy.	01970			

Minnesota Department of Health

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01970	Continued From page 71 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the building of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all three residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Upon entrance to the facility on September 11, 2023, at 10:45 a.m. the surveyor observed the	03090			

Minnesota Department of Health

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03090	Continued From page 72 front entrance and entryway of the facility. No electronic monitoring signage was observed. On September 11, 2023, at 12:00 p.m. licensed assisted living director (LALD)-A stated they did not have electronic monitoring in place at this time and there was no sign displayed in statutory language to disclose possible electronic monitoring activity. LALD-A stated he was not aware of the regulation for this posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 09/26/23
Time: 14:51:32
Report: 8058231227

Food and Beverage Establishment Inspection Report

Page 1

Location:

Highview Home Care LLC
1460 Farrington Street
St Paul, MN 55117
Ramsey County, 62

Establishment Info:

ID #: 0042028
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

No NEW orders were issued during this inspection.

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

ACTUAL INSPECTION TOOK PLACE 9/11/23 REPORT DATE IS THAT WHICH THE
ESTABLISHMENT BECAME ACCESSIBLE TO REPORT WRITING PROGRAM

HRD INSPECTOR: DEB JACOBSON
ESTABLISHMENT REP: AHMED ADAM

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

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 8058231227 of 09/26/23.

Certified Food Protection Manager: AHMED ADAM

Certification Number: 114287 Expires: 12/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us