DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 9, 2023

Licensee
Harbor Crossing
4650 Centerville Road
Saint Paul, MN 55127

RE: Project Number(s) SL32991015

Dear Licensee:

On June 8, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 12, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

May 5, 2023

Licensee
Harbor Crossing
4650 Centerville Road
Saint Paul, MN 55127

RE: Project Number(s) SL32991015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32991015 On April 10, 2023, through April 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 111 active residents; 46 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 11, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel ((ULP)-B) during activities of daily living (ADL), medication administration and blood glucose monitoring for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 April 11, 2023, at 7:20 a.m., the surveyor observed ULP-B prepare R2's morning medications. ULP-B failed to perform hand hygiene prior to medication preparation. ULP-B entered R2's apartment, sat the medications down, went into the bathroom, and failed to perform hand hygiene prior to the application of gloves. ULP-B administered R2's medications, assisted R2 with dressing, obtained a wet washcloth, and wiped R2's face and underarms.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 3 ULP-B removed the disposable gloves, disposed of the gloves, but failed to perform hand hygiene after the removal of the gloves. ULP-B gathered supplies to clean R2's perineum (area between the anus and vulva in the female). ULP-B failed to perform hand hygiene prior to the application of new gloves. ULP-B removed R2's soiled brief, washed R2's perineum area, and took soiled supplies into R2's bathroom. ULP-B did not change gloves, returned to R2's side, and pulled R2's clean brief and pants up to R2's waist. ULP-B removed the gloves, disposed of the gloves, and failed to perform hand hygiene after removal of the gloves. On April 11, 2023, at 8:45 a.m., the surveyor observed ULP-B gather supplies for blood glucose monitoring. ULP-B applied gloves but failed to perform hand hygiene before applying the gloves. ULP-B obtained a blood sample from R3 for blood glucose monitoring, disposed of the sharp lancet in the sharps container, removed the gloves, disposed of gloves, but failed to perform hand hygiene after removal of the gloves. On April 11, 2023, at 8:55 a.m., ULP-B stated he was taught to wash or sanitize his hands frequently. ULP-B stated he had not completed hand hygiene in between residents, before and after wearing gloves, and proceeded to the sink and washed his hands. ULP-B's education transcript indicated ULP-B was deemed competent in infection control techniques, including handwashing and personal protective equipment use, on October 5, 2022. On April 11, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-D stated hand hygiene should be performed in between residents and before	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 4 and after wearing gloves. The licensee's Infection Control Standard Precautions policy dated 2020, indicated it is the policy of this facility that hand hygiene procedures will be adhered to in order to prevent the transmission of pathogens. Hand hygiene should be performed: -before and after contact with the resident -before donning personal protective equipment -after removing personal protective equipment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 12, 2023, at approximately 11:30 a.m. with maintenance (M)-G and engineer (E)-H it was observed a light was not working in the exit stairway on second floor near resident room 244. Lighting in the means of egress is required for building occupants and emergency responders to navigate in an emergency. It was also observed a latch in the trash chute shaft assembly on second floor had a broken latch and would not positively latch. The latch is required to be maintained as part of the assembly of the trash chute as designed and installed. During the facility tour it was observed 2 exit signs were removed from exit doors in the lower level. One of the signs was removed on an exterior exit door from the Community Room in the lower level near the garage, and one was removed from an exterior exit door in the corridor near the lower-level Community Room. During an interview it was stated by M-G the exit signs were removed by maintenance staff. Exit signs are required to be maintained as designed, installed, and approved. These deficient conditions were visually verified by M-G and E-H accompanying on the tour.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed by a registered nurse (RN) within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel ((ULP)-B).	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01440	Continued From page 7 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-B was hired September 28, 2022. ULP-B's RA Medication Administration Training Evaluation Assisted Living dated October 11, 2022, indicated ULP-B completed and was found competent for the delegated task of medications administration. ULP-B's training record lacked documentation a RN supervised ULP-B within 30 calendar days of October 11, 2022 for the delegated task of medication administration. On April 11, 2023, at approximately 7:30 a.m., the surveyor observed ULP-B provide medication administration to multiple residents who resided in the licensee's secured unit. On April 12, 2023, at approximately 1:00 p.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated ULP-B was trained and found competent for the delegated task of medication administration, but ULP-B's record lacked documentation of a supervisory visit by the RN. CNS-D stated all supervisory visits would have been conducted at the licensee's location after ULP-B had completed training at licensee's corporate	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01440	Continued From page 8 location. The licensee's MN AL Delegation and Supervision Policy dated August 9, 2022, indicated an RN would complete supervision within 30 days for all tasks delegated to ULPs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=F	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 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.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for three of four residents (R2, R4, R5) and with change of resident condition for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CHANGE OF CONDITION R2 R2 was admitted on June 19, 2022. R2's most recent Assessment As Of Date was dated as completed on January 23, 2023, indicated that R2 was independent with transfers without adaptive equipment. R2's previous Assessment As Of Date was completed on October 12, 2022. R2's progress notes entered by the licensed practical nurse, dated February 23, 2023, indicated R2 was a heavy two person assist with transfers using a gait belt and her services were adjusted for her to be an EZ stand (mechanical lift) for all transfers. R2's progress notes did not indicate that R2 was assessed by a registered	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 10	01620		

nurse for this change in condition.

R2's signed Service Plan-Attachment E to Residency Agreement dated February 23, 2023, indicated that R2 required assistance with transfer assist mechanical lift.

90 DAY ASSESSMENTS
R2
R2 was admitted on June 19, 2022.

R2's most recent Assessment As Of Date was dated as completed on January 23, 2023. R2's previous Assessment As Of Date was completed on October 12, 2022. The duration between the two assessments was 103 days.

R4
R4 was admitted on June 19, 2022.

R4's most recent Assessment As Of Date was dated as completed on April 4, 2023. R4 previous Assessment As Of Date was complete on December 7, 2022. The duration between the two assessments was 118 days.

R5
R5 was admitted on June 28, 2022.

R5's most recent Assessment As Of Date was dated as completed on February 17, 2023. R5 previous Assessment As Of Date was complete on August 3. 2022. The duration between the two assessments was 198 days.

On April 12, 2023, at approximately 1:00 p.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D indicated the licensee was aware assessments were not completed within the required time frame. CNS-D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 11 stated the licensee had hired more nurses and had completed assessments on all residents to bring all assessment time frames into compliance. The licensee's MN AL Nursing Assessment Policy dated May 3, 2022, indicated assessments would be completed, "no less than every 90-days," from the previous assessment and with "change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 12 (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 the current service plan included a signature or other authentication by the licensee or resident or resident's representative to document agreement of services to be provided for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on June 19, 2022. On April 11, 2023, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B obtain R3's blood glucose reading per R3's service plan. R3's signed Service Plan- Attachment E to Residency Agreement dated June 19, 2022, indicated R3 received assistance with medication monitoring, bathroom assistance, reassurance checks, behavior management, blood sugar monitoring, homemaking, meal assistance, medication administration, shower assist, standard assistance am, standard assistance pm,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 13 unlimited escorts, and vital monitoring. R3's unsigned service plan printed April 11, 2023, identified by clinical nurse supervisor (CNS)-D as R3's current service plan, indicated R3 received all the above-mentioned services as well as laundry. Additionally, R3's service plan indicated a fee increase related to additional services provided. On April 11, 2023, at 12:25 p.m., CNS-D stated R3's daughter was having a hard time with changes and has not signed the new service agreement with the laundry service added. The licensee's MN AL Service Plans policy dated August 1, 2021, indicated service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. In addition, the policy indicated residents will be notified of changes to fees for service when applicable. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 14 review, the licensee failed to ensure medications were stored securely for two of four residents (R4, R5) with medications management services. In addition, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel to have access for all residents who resided in licensee's secured unit. 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: RESIDENT ROOMS R4 R4 was admitted on June 19, 2022. R4's Assessment As Of Date dated April 4, 2023, indicated R4 received medication management and read under the section Medication, "medications stored in locked med cart." Additionally, the assessment read in the same section, "Med Self Admin is no [sic] applicable." R5 R5 was admitted on June 28, 2022. R5's Assessment As Of Date dated February 17, 2023, indicated R5 received medication management and read under the section Medication, "medications are stored in secure med cart." Additionally, the assessment read in	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 15 the same section, "Med Self Admin is no [sic] applicable." On April 11, 2023, at approximately 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-F provided medications to R4 and R5 respectively. In R4's room, a bottle labeled, "stool stimulant," (a commonly over the counter medications used to treat constipation), was noted on R4's kitchen counter. In R5's room a bottle labeled, "Hydrocortisone 1% Spray," (a commonly used spray to treat minor skin irritations or rashes) was noted sitting on the middle of R5's kitchen table. On April 12, 2023, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-D indicated the medications located in R4 and R5's rooms should not be present. CNS-D indicated R4 and R5 were on medication management and all medications should have been secured in a locked medication cart for administration by the licensee. MEDICATION CART On April 11, 2023, at 8:15 a.m., the surveyor observed ULP-B preparing medications for a resident at one of the two medication carts in the secured unit. ULP-B walked away from the medication cart to administer medication to a resident and did not lock the medication cart. There were several residents sitting in chairs in the area of the medication cart. The surveyor was able to gain access to the medication cart drawers. The surveyor observed several residents' medications and medications cards in each of the medication drawers. ULP-B observed the surveyor looking in the unlocked medication cart, and ULP-B immediately walked to medication cart and locked it. On April 11, 2023, at 8:15 a.m., ULP-B stated the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 16 medication carts should be locked after each use. On April 11, 2023, at 8:15 a.m., registered nurse (RN)-E stated all staff have been educated to lock the medication carts when unattended. The licensee's AL Medication Management Policy dated March 6, 2023, indicated all medications would be stored in a locked medication cart to prevent medications errors or diversions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an opened date was placed on time sensitive medications stored in a secured medication cart which the licensee managed for residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01890	Continued From page 17 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: UNSECURED UNIT On April 11, 2023, at approximately 7:15 a.m., the surveyor completed an audit of the secured medication cart located on the second floor of the licensee's facility. In the top drawer of the medication cart, two medications were identified as being time sensitive. Unlicensed personnel (ULP)-F indicated both medications were currently in use for their prescribed residents. An Advair Diskus (an inhaled mediation used to treat asthma or chronic obstructive pulmonary disease (COPD)) was noted in a plastic zip lock style bag. The Advair Diskus' label contained a, "Pouch opened:" and "Use by:," area. Both areas were blank, and no dates were noted on any area of the device or the zip lock style bag it was contained in. A Trelegy Ellipta (an inhaled mediation used to treat asthma or chronic obstructive pulmonary disease (COPD)) was noted in a plastic zip lock style bag. The Trelegy Ellipta's label included two blank areas labeled, "Tray opened:," and "Discard (6 weeks):." Both areas were blank, and no dates were noted on any area of the device or the zip lock style bag it was contained in. The manufacture's Full Prescribing Information document revised August 2020, read, "Discard ADVAIR DISKUS 1 month after opening the foil pouch."	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01890	Continued From page 18 The manufacture's Full Prescribing Information document revised December 2022, read, "Discard TRELEGY ELLIPTA 6 weeks after opening the foil tray." SECURED UNIT On April 11, 2023, at 9:15 a.m., the surveyor completed an audit of the secured medication cart located in the secured unit of the licensee's facility. In the top drawer of the medication cart, three medications were identified as being time sensitive. ULP-B indicated both medications were currently in use for their prescribed residents. Two bottles of latanoprost (treats glaucoma) 0.005% eye drops for two different residents were noted in a plastic zip lock style bags. The latanoprost eye drops label contained a, "Opened:" and "Use by:," area. Both areas were blank, and no dates were noted on any area of the device or the zip lock style bag it was contained in. One bottle of dorzolamide/timolol (treats high pressure inside eye) 2%-0.5% eye drops were noted in a plastic zip lock style bag. The dorzolamide/timolol eye drops label contained a, "Opened:" and "Use by:," area. Both areas were blank, and no dates were noted on any area of the device or the zip lock style bag it was contained in. The manufacturer's instructions for latanoprost eye drops, dated December 2022, indicated the eye drops should be discarded six weeks after opening. The manufacturer's instructions for dorzolamide/timolol, dated January 2023, indicated the eye drops should be discarded 28	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01890	Continued From page 19 days after opening. On April 12, 2023, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-D indicated the licensee's expectations are all medications should be labeled when opened and all time sensitive meds must be discarded per manufacturers' instructions. CNS-D indicated ULPs should be labeling all meds when opened and nurses should have been completing medication cart audit routinely to ensure dates were in place. The licensee's AL Medication Management Policy dated March 6, 2023, indicated medications would be securely stored, but lacked instruction for dating or storage of medication per manufacturers' instruction. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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 20 (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 interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R5) who had ordered 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:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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 21 R5 was admitted on June 28, 2022. R5's Master Care Plan dated March 3, 2023, read, "Note: staff provide BG (blood glucose) checks QID (four times per day) ad [sic] notify facility nursing when out of range." R5's Med Sheet - HHA dated April 4, 2023, included four, "Blood glucose check," scheduled at 8:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. Each scheduled check included required documentation for the initials of the person who completed the check and the blood glucose result. R5's Service Charing Form - 1 week dated for April 5, 2023, through April 11, 2023, included the service Insulin Administration and Blood Sugar and read, "COMMONS: MD order will be obtained for parameters for when to notify for high or low blood sugar." R5's record lacked documentation of parameters to notify the nurse or licensed health professional when R5's blood glucose reads were out range based on a provider order. On April 12, 2023, at approximately 1:00 p.m., clinical nurse supervisor (CNS)-D stated R5's record should include parameters as ordered by a provider. CNS-D indicated all staff are trained to notify a nurse if any blood glucose readings are out of range, but R5's record lacked specific orders for the parameters ordered. The licensee's MN AL Treatment and Therapy Management Policy dated March 7, 2023, indicated provider orders for all treatments would be obtained prior to the initiation of any treatment services.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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 22 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure unlicensed personnel ((ULP)-B) followed appropriate repositioning techniques and transfer procedures for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included Alzheimer's dementia, deficiency of vitamin B, and other amnesia.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 23 R2's Service Plan- Attachment E to Residency Agreement dated February 23, 2023, indicated R2's services included transfer assist with mechanical lift. REPOSITIONING TECHNIQUES On April 11, 2023, at 7:20 a.m., the surveyor observed ULP-B assist with the repositioning of R2 from lying down in bed to sitting upright. ULP-B repositioned R2 by holding R2's hands and pulling R2 by the hands and arms until R2 reached the upright sitting position. ULP-B assisted R2 with dressing and several times during the assistance, R2 was unable to stay in a sitting position and would lean over to the side of the bed or backwards towards the wall. ULP-B repositioned R2 by placing a hand behind R2's neck and pulling R2 by the neck back into a sitting position. ULP-B failed to use proper body repositioning techniques when repositioning R2. TRANSFER PROCEDURES ULP-B pulled the standing lift (mechanical lift to assist with transfers) toward R2 and applied the lift sling (attachment used to fasten and secure a person to the mechanical lift) to R2 and attached the sling to the mechanical lift. ULP-B attempted to call another staff for assistance with the walkie talkie, but the battery was dead. ULP-B left R2 in the sling attached to the mechanical lift and went into the hallway to find another staff member to assist with R2's transfer. ULP-B was gone approximately two minutes. ULP-B returned to R2's apartment and stood beside R2 and waited for another staff member to arrive. Registered nurse (RN)-E entered R2's apartment and stood beside R2, together they used the mechanical lift to transfer R2 up above the bed. RN-E and ULP-B used the mechanical lift to move R2 from	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 24 above the bed area to above the wheelchair and once in place lowered R2 into the wheelchair. RN-E and ULP-B unattached the sling from the mechanical lift and removed the sling from R2. ULP-B failed to use proper transfer techniques by leaving R2 unattended and attached to the mechanical lift to find another staff member for assistance. ULP-B's RA Skills Competency dated October 5, 2022, indicated ULP-B was deemed competent on mechanical lifts, dressing a resident (weak arm), passive range of motion, move up in a bed using draw sheet, supine and side lying positioning placement. On April 11, 2023, at 8:15 a.m., ULP-B stated he had received his training at corporate, then shadowed another staff member onsite, and had some medication training with the RN onsite. On April 11, 2023, at 9:45 a.m., RN-E stated that all mechanical lifts in the facility require a two-person transfer and residents should not be left unattended and attached to the mechanical lifts. RN-E also stated that staff are trained on repositinong of a resident and should not pull on the resident's arms or neck to reposition them. The licensee's AL Mechanical Lift Transfer Policy updated October 11, 2022, indicated refer to the daily assignments or resident specific care plan for the number of staff required to assist with the mechanical lift. Obtain assistance if required. -If two staff are required for a full lift, two staff must be present for attaching the sling to the lift, and ensuring proper placement of the loops by each employee to confirm that the sling loops are attached appropriately. Two staff must remain present through the process of the transfer until	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 25 the lift is no longer engaged and the sling straps are unhooked. -For both the mechanical stand lift and the full body lift, staff are not to leave the resident out of visual line of sight while the resident is attached to the lift. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of one resident (R2) was treated with dignity and respect when unlicensed personnel ((ULP)-B) assisted with activities of daily living. 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 Alzheimer's dementia,	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
02350	Continued From page 26 deficiency of vitamin B, and other amnesia. R2's Service Plan- Attachment E to Residency Agreement, dated February 23, 2023, indicated R2's services included reassurance checks, extensive incontinence assist, extensive assist AM, extensive assist PM, transfer assistance mechanical lift, meal assistance, and unlimited escorts. On April 11, 2023, at 7:20 a.m., the surveyor observed ULP-B knock on R2's apartment door. ULP-B failed to wait for an answer from R2 and entered R2's apartment. ULP-B failed to ask R2's preference before ULP-B gathered R2's clothing for the day. ULP-B failed to inform R2 of the task before ULP-B removed R2's pants. ULP-B applied a pair of mismatched socks and a pair of shoes onto R2's feet. ULP-B failed to explain the task to R2 before ULP-B removed R2's shirt. R2 became visibly agitated and mumbled some nonsensical words and leaned backwards. ULP-B readjusted R2 into a sitting position by pulling R2 by the neck. ULP-B applied R2's bra and attached the back closure but R2's breasts were not in the bra cups and hung below the bra. Without adjusting R2's breasts into the bra cups, ULP-B applied R2's clean shirt over the bra. ULP-B escorted R2 in the wheelchair to the dining room and left her sitting at the table for breakfast. On April 11, 2023, at 8:15 a.m., ULP-B stated he had received his training at corporate, then shadowed another staff member onsite, and had some medication training with the RN onsite. ULP-B's RA Skills Competency dated October 5, 2022, indicated ULP-B was deemed competent to provide the essential services of the job based off of self-acknowledgement to include:	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
02350	Continued From page 27 -Review of the Bill of Rights, Assisted Living Bill of Rights, and Ombudsman Programs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *04/11/23*
Time: 12:59:00
Report: 1023231083

Food and Beverage Establishment Inspection Report

Location:
Harbor Crossing
4650 Centerville Road
White Bear Lake, MN55127
Ramsey County, 62

Establishment Info:
ID #: 0039283
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516533288
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED DELI SLICER STORED WITH FOOD DEBRIS ON IT. CLEAN THIS EQUIPMENT AND STORE IN A CLEAN CONDITION WHEN NOT IN USE.

Comply By: 04/11/23

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

OBSERVED CUTTING BOARDS TO HAVE DEEP CUT MARKS AND DISCOLORATION. REPAIR/REPLACE THIS EQUIPMENT.

Comply By: 04/11/23

Surface and Equipment Sanitizers

S&S: = 700PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Hot Water: = at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 151 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

THIS FACILITY CONSISTS OF A FULL SERVICE KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

ROP BAG SOUPS ARE DONE AT COMMISSARY KITCHEN:
Optage Meals
1375 Terrace Dr
Roseville, MN 55113

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

Type: Full
Date: *04/11/23*
Time: 12:59:00
Report: 1023231083
Harbor Crossing

Food and Beverage Establishment Inspection Report

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 1023231083 of 04/11/23.

Certified Food Protection Manager: DANIEL AMESBURY

Certification Number: 110258 Expires: 03/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

DANIEL AMESBURY
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us