Electronically Delivered

June 20, 2023

Licensee
New Life Health Service
1586 Beech Street
Saint Paul, MN 55106

RE: Project Number(s) SL38377015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on May 15, 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 and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this survey of your facility.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

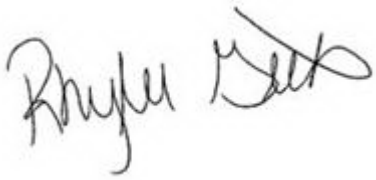
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Evaluation Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38377	A. BUILDING: _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	1586 BEECH STREET SAINT PAUL, MN 55106

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#38377015 On May 15, 2023, through May 16, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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; 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 interview and record review, the licensee failed to develop an individualized abuse prevention plan (IAPP) that addressed all areas of listed vulnerabilities and potential abuse, and implement specific interventions to reduce the risk of abuse for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 medical record was reviewed. R2 admitted to the facility on February 13, 2023. R2's diagnoses included dementia and diabetes insipidus. R2's service plan dated February 23, 2023,	0 630		

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0 630	Continued From page 2 indicated R2 received assistance with personal cares and medication administration. R2's assessment dated February 13, 2023, indicated R2 was at risk for wandering. Staff were to perform safety checks every two hours. R2 was aggressive and combative. Staff were to provide supervision, monitoring, and a calm environment to help manage his behaviors. R2's IAPP dated February 13, 2023, indicated R2 was susceptible to behaviors such as consuming inedible materials (pica), drinking liquid soap, and physical aggression. R2's IAPP lacked evidence R2 was assessed for his risk of abusing other vulnerable adults with statements of specific measures to be taken to minimize his risk of abusing others. In addition, R2's IAPP failed to address his assessed behaviors of aggression and self-injurous behaviors along with specific measures to be taken to minimize his risk of self-injurous behaviors and physical aggression. R2's IAPP did not address or include specific interventions for his assessed risk of wandering as indicated in his nursing assessment dated February 13, 2023. A licensee IAPP policy was requested but not provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 3 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) containing all the requirements outlined in Appendix Z and posted prominently. This had the potential to affect all residents, staff, and visitors. 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 the potential to affect a large portion or all the residents).	0 680		

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0 680	Continued From page 4 The findings include: On May 15, 2023, at 9:25 a.m., the surveyors observed an emergency preparedness plan posted on a wall in the licensee's living room. During the entrance conference on May 15, 2023, at 10:25 a.m., licensed assisted living director (LALD)-C provided the surveyors with the licensee's emergency preparedness plan (EPP) binder. The licensee's EPP lacked the following components: #4. EP program for Patient Population -Only listed the incident commander and a registered nurse, but did not identify other delegations of authority. Back-up incident commander section was blank. #7. Subsistence Needs for Staff and Patient -Food water, medical supplies, pharmeutical supplies. Did not specifically address food, water, where medications would be stored or kept in an emergency or evacuation. Did not address safe/sanitary storage of provisions. -Did not have a policy and procedure for food, water, and pharmaceutical supplies. #14. Roles Under a Waiver Declared by Secretary -Did not address this in their EPP. -Lacked a policy and procedure. On May 15, 2023, at 11:30 a.m., LALD-C confirmed the licensee's EPP lacked the listed components.	0 680		

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0 680	Continued From page 5 TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for three of two of two residents (R1, R2) were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 15, 2023, at 10:20 a.m., licensed assisted living director (LALD)-C said resident documentation was both electronic and paper, but only the side rail	0 720		

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0 720	Continued From page 6 assessments and individual abuse prevention plans were on paper. On May 15, 2023, at 12:38 p.m., surveyors asked LALD-C for R1 and R2's treatment management plans. During the exit conference on May 16, 2023, at 12:02 p.m., LALD-C said the treatment plans were not on site or in the electronic system. LALD-C acknowledged R1 and R2's medical records should have included their treatment plans. LALD-C said she would locate the treatment plans and send them to surveyors. On May 16, 2023, at 4:31 p.m., LALD-C emailed surveyors R1 and R2's treatment plans. Licensee's policy, Treatment and Therapy Management Plan, no date, indicated treatment of therapy services would be incorporated into the service plan and individualized treatment/therapy plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 720		
0 810 SS=E	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	0 810		

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0 810	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to have accurate content on the home's fire safety and evacuation plan for employees and residents. This has the potential to directly affect the safety of staff and residents receiving assisted living care. 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	0 810		

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0 810	Continued From page 8 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 15, 2023, at approximately 2:20 p.m., a document review and interview with the unlicensed personnel (ULP)-D and the registered nurse (RN)-C on the home's fire safety and evacuation plan documentation indicated: 1. The safety information sheet that included fire safety information and important telephone numbers (undated) incorrectly indicated the home's fire extinguisher was located in the basement when the home does not have a basement. 2. The fire emergency plan information sheet (undated) for residents and staff incorrectly indicated there are egress windows and emergency exit diagrams posted in the lower-level exit when the home does not have a lower-level floor. 3. The licensee has an agreement with their New Hope home location for their alternate housing site during an emergency evacuation but the home's evacuation plan documentation (item #7) incorrectly listed the Brooklyn Park or the Golden Valley location. On May 15, 2023, at approximately 2:35 p.m., during the interview, the ULP-D and the RN-C verified the above findings and acknowledged the discrepancies in the home's fire safety and evacuation documentation. Survey staff explained that inaccurate fire safety and evacuation in the home's documentation will cause confusion and	0 810		

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0 810	Continued From page 9 delay in evacuation of residents during a fire or similar emergency. The ULP-D commented that he will immediately revise the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950		

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0 950	Continued From page 10 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representatives' statutory language for one of one residents (R1) with record reviewed. This deficient practice affected all residents. 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 the potential to affect a large portion or all the residents). The findings include: 144.50 Subd. 3. "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R1 admitted on March 10, 2023. R1's New Life Health Service's Assisted Living	0 950		

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0 950	Continued From page 11 Contract dated March 10, 2023, lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. On May 16, 2023, at 12:02 p.m., licensed assisted living director (LALD)-C acknowledged the required verbatim notice was not included in the residents' records. LALD-C said she asked residents if they want a representative, but documentation lacked required verbatim notice. LALD-C said the assisted living contract was provided to all residents. Licensee's policy, Assisted Living Contracts, no date, indicated Clients have a right to designate a representative before they sign a contract. The policy indicated the right to designate a representative for certain purposes would be on a document separate from the contract. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by:	0 980		

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0 980	Continued From page 12 Based on interview and record review, the licensee failed to ensure the assisted living contract included an arbitration provision for one of one residents (R1) with records reviewed. This deficiant practice affected all residents. 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 the potential to affect a large portion or all the residents). 144G.51 (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. R1 admitted on March 10, 2023. R1's New Life Health Service's Assisted Living Contract dated March 10, 2023, lacked any arbitration provision. On May 16, 2023, at 12:02 p.m., licensed assisted living director (LALD)-C said the assisted living contract was provided to all residents. LALD-C acknowledged the lack of any arbitration provision. Licensee's policy, New Life Health Service Assisted Living Contracts, no date, indicated licensee would disclose in writing, in the contract, any arbitration provision that precludes, limits, or delays the ability of a resident from taking a civil action.	0 980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38377	A. BUILDING: _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	1586 BEECH STREET SAINT PAUL, MN 55106

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0 980	Continued From page 13 TIME PERIOD OF CORRECTION: Twenty-One (21) Days	0 980		
01440 SS=F	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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services to residents for two of two unlicensed personnel (ULP-A, ULP-B) with	01440		

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01440	Continued From page 14 records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on May 4, 2022. ULP-A's employee record lacked evidence a RN conducted direct supervision of her preforming delegated tasks within 30 days from the date she first performed delegated tasks. ULP-B was hired on June 6, 2022. ULP-B's employee record lacked evidence a RN conducted direct supervision of her performing delegated tasks within 30 days from the date she first performed delegated tasks. On May 16, 2023, at 12:02 p.m., licensed assisted living director (LALD)-C acknowledged employee files lacked evidence a RN conducted direct supervision of ULP's 30 days after they preformed delegated tasks. Licensee's policy, New Life Health Service Competency Evaluations, no date, lacked information regarding RN supervision of ULP's within 30 calendar days after the date on which the ULP begins working for the facility and first performs delegated tasks. TIME PERIOD OF CORRECTION: Twenty-One	01440		

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01440	Continued From page 15 (21) Days	01440		
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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two residents (R2) received all of his required services as indicated in R2's record. 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	01640		

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01640	Continued From page 16 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 medical record was reviewed. R2 admitted to the facility on February 13, 2023. R2's diagnoses included dementia with behavioral disturbances and diabetes. R2 walked independently. R2's assessment dated February 13, 2023, indicated R2 received a daily morning blood sugar check performed by unlicensed personnel (ULP). R2 was at risk for wandering. Staff were to perform safety checks every two hours. R2 was aggressive and combative. Staff were to provide supervision, monitoring, and a calm environment to help manage his behaviors. R2's physician order sheet dated February 13, 2023, indicated on February 6, 2023, and updated March 15, 2023, R2's provider indicated staff were to check R2's blood sugar (glucose) level before meals. Staff were to notify the registered nurse (RN) if R2's blood glucose was below 70 or above 300 mg/dL. Safety checks were to be performed every two hours at night. R2's care plan indicated he was supposed to receive daily assistance with medication administration, overnight safety checks at 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., and as needed (PRN), three diabetic snacks at 2:00 p.m., 5:00 p.m., and 8:00 p.m., twice daily supervision to help manage and redirect his aggressive/combative behaviors, daily assistance with wandering.	01640		

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01640	Continued From page 17 R2's care plan had conflicting information regarding the number blood sugar (glucose) checks R2 was supposed to receive on a daily basis. Under the category titled "Blood Glucose Checks," were directions for staff to perform blood glucose checks three times per day with a listed time of 12:00 p.m. Under the category titled "Diabetic Status," staff were to perform a blood glucose check every morning. R2's signed service plan dated February 13, 2023, indicated R2 was to receive assistance with medication administration with staff to administer after R2's medications were set-up by the nurse, blood glucose monitoring three times per day with staff to document in the licensee's electronic health charting system (EHR), daily bathing/shower, continence care after every bowel movement, three meals and two scheduled snacks at 2:00 p.m., 8:00 p.m.. R2's service plan did not include R2's overnight safety checks every two hours, twice daily assistance for his aggressive behaviors, and staff assistance for his assessed risk of wandering. R2's service delivery record dated May 1-15, 2023, lacked documentation R2 received the following services: Medication administration on 14 out of 15 days. Safety checks on 14 out of 15 days. Daily shower on 13 out of 15 days Blood sugar checks on 14 out of 15 days. R2's care plan, service plan, and service delivery record lacked consistent information regarding the services R2 was supposed to receive. On May 15, 2023, at 10:45 a.m., licensed	01640		

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01640	Continued From page 18 assisted living director (LALD)-C stated she developed resident service plans based off their initial nursing assessments. LALD-C stated service plans were updated when there was a change in the resident's services or condition. The licensee's undated policy titled Service Plan, indicated service plans were based on the resident's assessment and preferences, and were consistent with accepted standards of practice for professional nursing or other relevant standards. TIME PERIOD TO CORRECT: Seven (7) 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	01650		

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01650	Continued From page 19 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 interview and record review, the licensee failed to ensure service plans included the required content for two of two residents (R1, R2) with records reviewed. This deficient practice affected all 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 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 medical record was reviewed. R1 admitted to the facility on March 10, 2023. R1's diagnoses included a brain stem stroke syndrome. R1 had left side deficit. R1's service plan dated March 9, 2023, indicated R1 received assistance with personal cares, medication administration, meals, housekeeping, and laundry. R1's service plan indicated R1 she required range of motion exercises and compression socks.	01650		

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01650	Continued From page 20 R1's service plan lacked the fees for services provided, and a contingency plan; action to be taken in the scheduled services could not be provided. R2 R2's medical record was reviewed. R2 admitted to the facility on February 13, 2023. R2's diagnoses included dementia and diabetes insipidus. R2 walked independently. R2's service plan dated February 13, 2023, indicated R2 received assistance with personal cares, medication administration, meals, housekeeping, and laundry. R2's service plan indicated he was supposed to receive blood sugar checks three times per day. R2's service plan lacked the fees for services provided, and a contingency plan; action to be taken if the scheduled services could not be provided. During an interview on May 15, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated he was responsible for developing the service plans. The licensee's undated policy titled Service Plan, indicated resident service plans would include: the fees for services, an a contingency plan for circumstances when services could not be provided. TIME PERIOD TO CORRECT: Seven (7) days.	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 21 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (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 ensure a treatment management plan was developed for one of two residents (R2) reviewed who received blood glucose monitoring. This practice resulted in a level two violation (a	01940		

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01940	Continued From page 22 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 medical record was reviewed. R2 admitted to the facility on February 13, 2023. R2's diagnoses included diabetes and dementia with behavioral disturbances. R2's physician order sheet dated February 13, 2023, indicated on February 6, 2023, and updated March 15, 2023, R2's provider indicated staff were to check R2's blood sugar (glucose) level before meals. Staff were to notify the registered nurse (RN) if R2's blood glucose was below 70 or above 300 mg/dL. R2's service plan dated February 13, 2023, indicated R2 required staff assistance with blood glucose checks three times per day. On May 15, 2023, at 1:00 p.m., unlicensed personnel (ULP)-A was observed entering R2's room to perform a blood glucose check on R2. On May 16, 2023, at 9:20 a.m., licensed assisted living director (LALD)-C stated she did develop an individualized treatment plan for R2 blood glucose monitoring but stated the document was at LALD-C's office located at another facility building the licensee owned. LALD-C told surveyors she would email R2's individualized treatment and therapy management plan by the end of the day.	01940		

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01940	Continued From page 23 On May 16, 2023, at 4:33 p.m., LALD-C emailed a document with R2's name listed at the top. The document was titled, "Treatment/Therapy Management Plan." Review of the document listed the following services provided/delegated to ULP: blood glucose monitoring daily at noon, COVID-19 protocol for oxygen saturation, and skilled nursing activities of daily living (ADLs). The document listed five categories with three options with checkboxes for licensed staff to check. The categories included (a) documentation of specific resident instructions relating to the administration of treatments/therapies; (b) staff to notify a licensed nurse or licensed health professional if a problem arose with a treatment/therapy including refusals and potential treatment accuracies with specific parameters; (c) resident specific requirements relating to documenting treatments/therapies; (d) verification all treatments/therapy services were administered as prescribed or ordered; (e) monitoring of treatment or therapy to prevent possible complications or adverse reactions. All five categories checked the option, "in electronic health records (EHR)/service tasks." On May 17, 2023, at 3:02 p.m., LALD-C stated the option EHR/service tasks referred to R2's service delivery record. Review of R2's service delivery record dated May 2023, indicated only the day, time, and staff initials of when blood glucose readings were performed. R2's record failed to include evidence of a written individualized treatment or therapy management plan for blood glucose testing.	01940		

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01940	Continued From page 24 The licensee's undated policy titled Treatment and Therapy Management Plan, indicated individualized treatment/therapy plan and management record included the following: (a) written statement of the treatment or therapy provided; (b) documentation of specific instructions that relate to providing the treatment or therapy administration; (c) identification of treatment/therapy tasks delegated to ULP; (d) procedures for notifying a registered nurse (RN) if problem arose with the treatment or therapy; (e) resident specific requirements that relate to documentation of treatments or therapy services; (f) frequency of supervision of personnel who provide the delegated treatment or therapy; (g) verification of RN that services were administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions. TIME PERIOD TO CORRECT: Seven (7) days.	01940		

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

Type: Full
Date: *05/15/23*
Time: 13:38:19
Report: 8058231117

Food and Beverage Establishment Inspection Report

Location:
New Life Health Service
1586 Beech Street
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0041257
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.

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at --- Degrees Fahrenheit
Location: SPRAY
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTION

SMALL RESIDENTIAL HOME, RESIDENTIAL NEIGHBORHOOD, NON COMMERCIAL FINISHES AND FIXTURES

NO ORDERS ISSUED

Type: Full
Date: *05/15/23*
Time: 13:38:19
Report: 8058231117
New Life Health Service

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 8058231117 of 05/15/23.

Certified Food Protection Manager: RODNEY CLIENE

Certification Number: 108192 Expires: 10/24/24

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