



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 22, 2024

Licensee

Deep Harmony Home Care LLC

8051 Hornell Avenue South

Cottage Grove, MN 55016

RE: Project Number(s) HL393479786M/HL393473682C & SL39347015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a complaint investigation (Project Number HL393479786M/HL393473682C) on December 7, 2023, and an initial survey (Project Number SL39347015) on February 16, 2024, for the purpose of assessing compliance with state licensing statutes.

On January 26, 2024, you received a Notice of Initial License Denial from the Minnesota Department of Health (MDH) as a result of a finding of substantiated maltreatment based on the complaint investigation (HL393479786M/HL393473682C) completed on December 7, 2023. After further review, and following the initial survey of February 16, 2024 (SL39347015) indicating the licensee is in substantial compliance, **the initial license denial is rescinded.**

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 of licensure** in the meantime. If you have not received a letter from MDH 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.

STATE CORRECTION ORDERS

The enclosed State Forms documents the state correction orders related to the complaint investigation and initial survey. 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fines of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. MDH may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

In response to the December 7, 2023, complaint investigation, (HL393479786M/HL393473682C), the provisional licensee was determined to be responsible for the following instance(s) of substantiated maltreatment. The fine related to this substantiated maltreatment finding was not imposed in the January 26, 2024, notice due to the initial license denial. **Because the initial license denial is rescinded, the following fine will be imposed against your license:**

R1 - HL393479786M - Substantiated Maltreatment - \$1,000.00

The total amount you are assessed is \$1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRDAppealsForm>.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

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If you have any questions, please contact Renee Anderson directly at: 651-201-5871.

Sincerely,



Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39347	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2024
NAME OF PROVIDER OR SUPPLIER DEEP HARMONY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8051 HORNELL AVENUE SOUTH COTTAGE GROVE, MN 55016			
(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 INITIAL COMMENTS: SL39347015-0 On February 12, 2024, through February 16, 2024, the Minnesota Department of Health conducted a survey at the above provider. At the time of the survey, there were 2 residents; both of whom received services under the Assisted Living license. As a result of the survey, the licensee was found to be in compliance with the assisted living statutes 144G.08 through 144G.95.	0 000			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL393473682C/HL393479786M On December 7, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was one resident receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL393473682C, tag identification 0900, 1060, 1070, 1640, 1940, 1970, 2320. The following correction order is issued for #HL393479786, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any	0 900			

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0 900	Continued From page 1 individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 900			

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0 900	Continued From page 2 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: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1 admitted to the facility on June 7, 2023, after completing a hospital stay. R1 was admitted to the hospital on June 27, 2023, and did not return to the facility. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. R1's progress notes indicated on June 7, 2023, the resident refused to sign his lease and service agreement. Facility staff attempted to get the resident to sign a contract on June 15, 2023, but the resident refused again. R1's record lacked evidence the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; - the facility must offer the resident the opportunity to identify a designated representative; and -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a	0 900			

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0 900	Continued From page 3 new contract or an addendum to the existing contract must be executed and signed. On December 7, 2023, at 12:30 p.m., registered nurse (RN)-A confirmed the facility provided direct care and services to the resident from June 7, 2023, through June 27, 2023, including medication and treatment management services, despite no signed contract in place. RN-A stated she had tried to get the resident to sign a contract but he refused. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060			

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01060	Continued From page 4 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01060			

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01060	Continued From page 5 situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1 admitted to the facility on June 7, 2023. R1 was admitted to the hospital on June 27, 2023, and did not return to the facility. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. R1's progress notes lacked documentation of when or why the resident was sent to the hospital. The resident was admitted to the hospital on June 27, 2023, and discharged to another facility on July 12, 2023, after spending 15 days in the hospital awaiting alternative placement. R1's facility discharge summary indicated "the past three weeks have been challenging for our staff as we are not able to continue to provide the level of care needed for [R1]...His condition has deteriorated and we are concerned about his safety and the safety of team, since we are not able to provide the level of care he needs at the moment. He was transferred to the emergency room and evaluated for the following: a urinalysis, MRSA culture of wounds, further respiratory assessment. He was admitted on June 27, 2023, for pulmonary edema and increased pain and discomfort. After conversations with case manager and care coordinator, it was decided that [R1] needed a long term care facility for	01060			

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01060	Continued From page 6 placement." Hospital admission records indicated the resident admitted on June 27, 2023, after being sent to the emergency room from a psychiatric clinic. The note indicated the resident "was found to have maggots in left leg wound," as well as cardiomegaly (enlarged heart), pulmonary edema (a fluid build up in the lungs that makes it difficult to breathe) and a BNP (B-type Natriuretic Peptide test, a test that measures BNP protein in your blood. When the heart works harder to pump blood, it makes more BNP) of 2,407 (normal levels are less than 100, levels over 900 can indicate acute heart failure)." The resident was admitted for CHF (congestive heart failure) and cellulitis of left lower extremity (a bacterial infection). Hospital documentation also indicated the facility would not accept the resident back. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the	01060			

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01060	Continued From page 7 Office of Ombudsman for Long-Term Care with in four days that R1 had been relocated and had not returned to the facility. On December 6, 2023, documentation of a written notice and notification of the Office of Ombudsman for Long-Term Care was requested, but not provided. On December 7, 2023, licensed assisted living director/registered nurse (LALD/RN)-A stated she had only talked to the Ombudsman after they reached out to her. LALD/RN-A stated she did not send a notice because she didn't have authorization to disclose information on the resident since he refused to sign an assisted living contract or his service plan. The licensee's Contract Termination policy, dated April 1, 2023, indicated the licensee would follow proper procedure for terminating an assisted living contract with a resident. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060			
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01070			

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01070	Continued From page 8 licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. 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). Findings include: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1 admitted to the facility on June 7, 2023, after completing a 33 day stay an an inpatient psychiatric facility. R1 was admitted to the hospital on June 27, 2023, and did not return to the facility. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. R1's progress notes lacked documentation of when or why the resident was sent to the hospital.	01070			

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01070	Continued From page 9 R1's record lacked a termination notice. The resident was admitted to the hospital on June 27, 2023, and discharged to another facility on July 12, 2023, after spending 15 days in the hospital awaiting alternative placement. R1's facility discharge summary indicated "the past three weeks have been challenging for our staff as we are not able to continue to provide the level of care needed for [R1]...His condition has deteriorated and we are concerned about his safety and the safety of team, since we are not able to provide the level of care he needs at the moment. He was transferred to the emergency room and evaluated for the following: a urinalysis, MRSA culture of wounds, further respiratory assessment. He was admitted on June 27, 2023, for pulmonary edema and increased pain and discomfort. After conversations with case manager and care coordinator, it was decided that [R1] needed a long term care facility for placement." Hospital admission records indicated the resident admitted on June 27, 2023, after being sent to the emergency room from a psychiatric clinic. The note indicated the resident "was found to have maggots in left leg wound," as well as cardiomegaly (enlarged heart), pulmonary edema (a fluid build up in the lungs that makes it difficult to breathe) and a BNP (B-type Natriuretic Peptide test, a test that measures BNP protein in your blood. When the heart works harder to pump blood, it makes more BNP) of 2,407 (normal levels are less than 100, levels over 900 can indicate acute heart failure)." The resident was admitted for CHF (congestive heart failure) and cellulitis of left lower extremity (a bacterial infection). Hospital documentation also indicated	01070			

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01070	Continued From page 10 the facility would not accept the resident back. Documentation from a provider at the hospital indicated the resident was sent to an appointment at his psychiatric clinic with a note to the psychiatrist the resident had been refusing wound care. The documentation indicated, "patient transported to appointment by group home staff who left patient with an envelope. Inside the envelope the provider noted a letter indicating the patient has been non-compliant with cares, not allowing wound cares, irritable, and with ongoing agitation/aggression. The note indicated a desire to have the patient sent to the ED (emergency department) for evaluation. [psychiatrist] called [the facility] and spoke to staff, notifying them that this is not the appropriate method for seeking care for patient if having concerns. Provider attempted to assess the patient's ability to verbalize understanding of consequences of refusing wound cares but patient would not engage. Patient refused voluntary ED transport so provider placed T-hold to have patient transported to ED for further assessment." Additional documentation from the resident's psychiatrist indicated the psychiatrist spoke with facility staff during the visit and "told them this is extremely inappropriate and if they think he needs emergency care they should not be taking him to an outpatient appointment and using me as a work-around." Documentation from hospital case managers indicated they had been told by the facility the resident could not return since he hit staff and was aggressive with staff and residents. On December 7, 2023, at 12:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they did the best they could	01070			

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01070	Continued From page 11 to provide care for R1 and she "felt like the push was the hospital didn't want to keep him at that time and after just three days wanted to send him back, I felt like I was advocating for him because he needs a bit more care." LALD/RN-A stated she tried to help the case manager find alternative placement when they asked her to help and they were providing services as best they could. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070			
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.	01640			

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01640	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of one residents (R1). In addition, the licensee failed to ensure the service plan include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1 admitted to the facility on June 7, 2023, after completing a hospital stay. R1 was admitted to the hospital on June 27, 2023, and did not return to the facility. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. The service plan lacked documentation of wound care services the resident was receiving.	01640			

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01640	Continued From page 13 R1's progress notes indicated on June 7, 2023, the resident refused to sign his lease and service agreement. Facility staff attempted to get the resident to sign a contract on June 15, 2023, but the resident refused again. R1's most recent assessment dated June 21, 2023, indicated the resident received wound care for bilateral venous stasis ulcers. The resident was noted to have wounds that require frequent monitoring. Four individual open areas were documented in the assessment. On December 7, 2023, at 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was not aware treatments needed to be on the service plan and she had been reading the statutes trying to understand them but didn't realize that was a requirement for the service plan. LALD/RN-A stated she was not able to get the resident to sign the service plan as he always refused. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
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	01940			

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01940	Continued From page 14 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01940			

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01940	Continued From page 15 The findings include: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. The service plan lacked wound care services. R1's record contained an incident report dated June 8, 2023, for "weeping ulcers on bilateral lower extremities." The report indicated there was a left anterior open area about 2 centimeters (cm) by 4 cm and the right posterior side had a 4 cm by 6 cm open area. The legs were noted to be swollen with pitting edema and malodorous drainage was present. The lower extremities were "wrapped in ace wrap with gauze dried and stuck to the open areas. There was offensive odor to the wound. Wound cleansed with water and house standing orders for wound care initiated." Additional notes indicated staff would continue to "monitor wound and follow up with PCP when one is identified. Request wound consult from PCP." R1's most recent assessment dated June 21, 2023, indicated the resident received wound care for bilateral venous statis ulcers. The resident was noted to have wounds that require frequent monitoring. Four individual open areas were documented in the assessment. One was a 2 cm by 4 cm open area (non stageable), another was 3 cm by 6 cm, open, weepy wounds (non-stageable), the third was a 2 cm by 2 cm small cluster of open skin, the fourth was a 1 cm by 1 cm open area with 3+ pitting edema.	01940			

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01940	Continued From page 16 R1's June 2023 Treatment Administration Record (TAR) included "monitor BLE [bilateral lower extremities] open area and apply dressing per HSO [house standing order]." Monitoring was to be done every other day in the evenings starting on June 7, 2023. The TAR indicated the resident refused monitoring on June 7, June 12, and June 16. The resident had a dressing applied on June 8, June 10, June 14, June 18, and June 20. R1's record lacked orders for wound care and a treatment management plan to contain the following required content: -type of service to be provided; -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed personnel; and -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. On December 11, 2023, at 10:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A was asked where R1's treatment management plan could be located. LALD/CNS-A stated she was familiar with the statutes and the requirements for a treatment management plan but would "have to review the policy, I don't think I can answer that." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940			

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01940	Continued From page 17 days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one residents (R1) who received wound care treatments managed by the provider. 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: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with	01970			

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01970	Continued From page 18 deep room cleaning, laundry, behavior management, and medication administration. The service plan lacked wound care services. R1's record contained an incident report dated June 8, 2023, for "weeping ulcers on bilateral lower extremities." The report indicated there was a left anterior open area about 2 centimeters (cm) by 4 cm and the right posterior side had a 4 cm by 6 cm open area. The legs were noted to be swollen with pitting edema and malodorous drainage was present. The lower extremities were "wrapped in ace wrap with gauze dried and stuck to the open areas. There was offensive odor to the wound. Wound cleansed with water and house standing orders for wound care initiated." Additional notes indicated staff would continue to "monitor wound and follow up with PCP when one is identified. Request wound consult from PCP." R1's most recent assessment dated June 21, 2023, indicated the resident received wound care for bilateral venous stasis ulcers. The resident was noted to have wounds that require frequent monitoring. Four individual open areas were documented in the assessment. One was a 2 cm by 4 cm open area (non stageable), another was 3 cm by 6 cm, open, weepy wounds (non-stageable), the third was a 2 cm by 2 cm small cluster of open skin, the fourth was a 1 cm by 1 cm open area with 3+ pitting edema. R1's record lacked orders for wound care and a treatment management plan. R1's June 2023 Treatment Administration Record (TAR) included "monitor BLE [bilateral lower extremities] open area and apply dressing per HSO [house standing order]." Monitoring was to be done every other day in the evenings starting	01970			

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01970	Continued From page 19 on June 7, 2023. The TAR indicated the resident refused monitoring on June 7, June 12, and June 16. The resident had a dressing applied on June 8, June 10, June 14, June 18, and June 20. R1's record contained Standing Medication Orders dated June 6, 2023, which contained a section for "topical medications for minor cuts and abrasions." The standing orders indicated triple antibiotic ointment should be used to "help prevent infection in minor cuts, scrapes, and burns." The order did not give any guidance on dressings or how often to change it. On December 11, 2023, at 10:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she felt the standing orders for wound care were sufficient and appropriate because "it wasn't like open open, it was more like dry skin and the pieces of dry skin that were unstageable so I feel like the house standing order would have sufficed for a week or two until we established a primary care provider." LALD/RN-A confirmed she did see documentation of venous statis ulcers in the resident's hospital paperwork but did not ask the hospital to send an order for wound care because "there was definitely urgency from the hospital to discharge the patient, personally I don't think all the orders came with [R1] because he came with papers with him and he didn't give them to us." LALD/RN-A stated the standing orders were signed by a hospitalist at the hospital the resident discharged from. No further information was provided.	01970			

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01970	Continued From page 20	01970			
	TIME PERIOD FOR CORRECTION: Seven (7) day				
02320 SS=G	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 interview and record review, the licensee failed to ensure reporting of resident condition to the appropriate supervisor or health care professional for one of one resident (R1). The licensee failed to notify the resident's primary care provider after ongoing refusals of care. Facility staff noted changes to the appearance and odor of a wound over several weeks and noted flies around the resident's wound one week before he was admitted to the hospital. The facility sent the resident to a psychiatrist appointment with a note updating the provider on the refusals of care. The psychiatrist sent the resident to the emergency room, where he was admitted for pulmonary edema and cellulitis, as well as maggots in the wound. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a	02320			

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02320	Continued From page 21 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizoaffective disorder, unspecified personality disorder, bipolar disorder, agitation, and autism spectrum disorder. R1 admitted to the facility on June 7, 2023, after completing a 33 day stay an an inpatient psychiatric facility. R1 was admitted to the hospital on June 27, 2023, and did not return to the facility. R1's unsigned service plan dated June 7, 2023, indicated the resident received assistance with deep room cleaning, laundry, behavior management, and medication administration. The service plan lacked wound care services. R1's record contained an incident report dated June 8, 2023, for "weeping ulcers on bilateral lower extremities." The report indicated there was a left anterior open area about 2 centimeters (cm) by 4 cm and the right posterior side had a 4 cm by 6 cm open area. The legs were noted to be swollen with pitting edema and malodorous drainage was present. The lower extremities were "wrapped in ace wrap with gauze dried and stuck to the open areas. There was offensive odor to the wound. Wound cleansed with water and house standing orders for wound care initiated." Additional notes indicated staff would continue to "monitor wound and follow up with PCP when one is identified. Request wound consult from PCP." R1's most recent assessment dated June 21, 2023, indicated the resident received wound care	02320			

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02320	Continued From page 22 for bilateral venous statis ulcers. The resident was noted to have wounds that require frequent monitoring. Four individual open areas were documented in the assessment. One was a 2 cm by 4 cm open area (non stageable), another was 3 cm by 6 cm, open, weepy wounds (non-stageable), the third was a 2 cm by 2 cm small cluster of open skin, the fourth was a 1 cm by 1 cm open area with 3+ pitting edema. R1's record lacked orders for wound care and a treatment management plan. R1's progress notes included the following entries: -June 10, 2023, staff noted "dark colored urine in client's urinal that almost looked like blood." The resident declined an offer to go to the hospital. -June 12, 2023, staff noted the resident appeared very short of breath and continued to smoke cigarettes about every 10-15 minutes. The resident refused to allow staff to check his weight or other vitals. -June 14, 2023, it was noted the resident's room "is in disarray with open cans of food, drinks, and other items all over the place. [R1] is refusing to sign a lease or service contract, making it difficult to care for him..." -June 16, 2023, staff noted a lump on the resident's back and asked if it had been there for a while. The resident "slapped the writer on the forearm..." and refused to go to the hospital for evaluation. -June 17, 2023, the resident was noted to "continue to be uncooperative and verbally abusive." -June 18, 2023, staff noted, "[R1] contines to appear short of breath using his accessory muscles in labored breathing. Writer convinced him to check his oxygen sats at 94% on room air	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39347	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/07/2023
NAME OF PROVIDER OR SUPPLIER DEEP HARMONY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8051 HORNELL AVENUE SOUTH COTTAGE GROVE, MN 55016		
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02320	Continued From page 23 (normal is above 95%). He claims this is his baseline and refused to consider being evaluated in an urgent care clinic or ED (emergency department) He continues to be verbally aggressive towards staf..." -June 19, 2023, staff noted "Encouraged client to take a shower today so that his dressings can be changed but he refused and promises that he'll take a shower another day. The wound is malodorous and there are flies around the client due to poor hygiene. He refuses to wash his hands and insists on getting into the shared refrigerator after touching his open wounds without washing his hands..." -June 21, 2023, staff noted, "[R1] continues to appear short of breath using his accessory muscles in labored breathing. He states that he's in a lot of pain and does not believe he had adequate pain management..." -June 23, 2023, staff noted the resident was "giving strong, offensive body odor due to poor hygiene. He is not taking showers and refusing wound dressing changes..." -June 26, 2023, staff noted the resident "continues to go out and smoke every 15-20 minutes while he continues to be short of breath, refusing oxygen saturation levels, and other cares offered by staff. He is drinking pop and very limited water. His wounds have very strong odors and he continues to pick at his wounds while at the dining table, then goes to fridge without washing his hands..." No additional progress notes were entered after June 26, 2023. R1's progress notes lacked documentation of when or why the resident was sent to the hospital. The resident was admitted to the hospital on June	02320			

Minnesota Department of Health

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02320	Continued From page 24 27, 2023, and discharged to another facility on July 12, 2023, after spending 15 days in the hospital awaiting alternative placement. R1's facility discharge summary indicated "the past three weeks have been challenging for our staff as we are not able to continue to provide the level of care needed for [R1]...His condition has deteriorated and we are concerned about his safety and the safety of team, since we are not able to provide the level of care he needs at the moment. He was transferred to the emergency room and evaluated for the following: a urinalysis, MRSA culture of wounds, further respiratory assessment. He was admitted on June 27, 2023, for pulmonary edema and increased pain and discomfort. After conversations with case manager and care coordinator, it was decided that [R1] needed a long term care facility for placement." Hospital admission records indicated the resident admitted on June 27, 2023, after being sent to the emergency room from a psychiatric clinic. The note indicated the resident "was found to have maggots in left leg wound," as well as cardiomegaly (enlarged heart), pulmonary edema (a fluid build up in the lungs that makes it difficult to breathe) and a BNP (B-type Natriuretic Peptide test, a test that measures BNP protein in your blood. When the heart works harder to pump blood, it makes more BNP) of 2,407 (normal levels are less than 100, levels over 900 can indicate acute heart failure)." The resident was admitted for CHF (congestive heart failure) and cellulitis of left lower extremity (a bacterial infection). Hospital documentation also indicated the facility would not accept the resident back. Documentation from a provider at the hospital	02320			

Minnesota Department of Health

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02320	Continued From page 25 indicated the resident was sent to an appointment at his psychiatric clinic with a note to the psychiatrist the resident had been refusing wound care. The documentation indicated, "patient transported to appointment by group home staff who left patient with an envelope. Inside the envelope the provider noted a letter indicating the patient has been non-compliant with cares, not allowing wound cares, irritable, and with ongoing agitation/aggression. The note indicated a desire to have the patient sent to the ED (emergency department) for evaluation. [psychiatrist] called [the facility] and spoke to staff, notifying them that this is not the appropriate method for seeking care for patient if having concerns. Provider attempted to assess the patient's ability to verbalize understanding of consequences of refusing wound cares but patient would not engage. Patient refused voluntary ED transport so provider placed T-hold to have patient transported to ED for further assessment." Additional documentation from the resident's psychiatrist indicated the psychiatrist spoke with facility staff during the visit and "told them this is extremely inappropriate and if they think he needs emergency care they should not be taking him to an outpatient appointment and using me as a work-around." Documentation from hospital case managers indicated they had been told by the facility the resident could not return since he hit staff and was aggressive with staff and residents. On December 7, 2023, at 12:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was "not surprised" his wounds were infected but did not know there were maggots in the wound. LALD/RN-A stated she had training in the mental health field and she	02320			

Minnesota Department of Health

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02320	Continued From page 26 felt comfortable they could meet R1's needs as long as he was taking his medications and engaging in activities. LALD/RN-A stated she thought she was doing good with his wounds and "he just kept refusing and refusing, it was hard. He didn't think we had the skillset. But, there were flies around his wound. I was looking for help because each time I tried to get [R1] to go to a clinic or primary care provider appointment he said he would charge me with kidnapping." On December 11, 2023, at 10:50 a.m., LALD/RN-A stated she felt notifying the pyschiatrist about the worsening wounds and refusals of care was the appropriate health professional to updated. LALD/RN-A stated, "Yes, absolutely, I feel like they're part of our collaborative team and I felt alone seeking help from the case managers and others, and I was told the resident has a right to refuse care so I wanted another set of eyes to say at which point do we respect his wishes and his refusal to receive care and at what point do we say more needs to be done." LALD/RN-A confirmed a primary care provider, physician, nurse practitioner, or physician assistant was not notified of the worsening wound and refusal of care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360			

Minnesota Department of Health

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02360	Continued From page 27 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.		

Type: Full
Date: 02/13/24
Time: 10:30:00
Report: 1005241042

Food and Beverage Establishment Inspection Report

Page 1

Location:

Deep Harmony Home Care LLC
8051 Hornell Ave S
Cottage Grove, MN55016
Washington County, 82

Establishment Info:

ID #: N000123
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/BEEF
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH OPERATIONS LEADER AND REVIEWED WITH HRD NURSE EVALUATOR ROBYN WOOLLEY.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

ESTABLISHMENT HAS A MAXIMUM REGISTERING THERMOMETER AND LATER SENT INSPECTOR A PICTURE SHOWING THAT THE DISHWASHER PROVIDED A UTENSIL SURFACE

Type: Full
Date: 02/13/24
Time: 10:30:00
Report: 1005241042
Deep Harmony Home Care LLC

Food and Beverage Establishment Inspection Report

Page 2

TEMPERATURE OF 162 DEGREES F (MINIMUM REQUIRED IS 160 DEGREES F).

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241042 of 02/13/24.

Certified Food Protection Manager SAMLINA CAWRAY

Certification Number: FM116738 Expires: 04/17/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

SARAH CASSELL
OPERATIONS LEADER

Signed: _____



Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us