DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 31, 2022

Administrator
Healing Homes Living Services
83 Cook Avenue West
Saint Paul, MN 55117

RE: Project Number(s) SL36561015

Dear Administrator:

On August 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 8, 2021, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

November 18, 2021

Administrator
Healing Homes Living Services
83 Cook Avenue West
Saint Paul, MN 55117

RE: Project Number(s) SL36561015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 8, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health also 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 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 1620 - 144g.70 Subd. 2 - Initial Reviews, Assessments, And Monitoring = $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

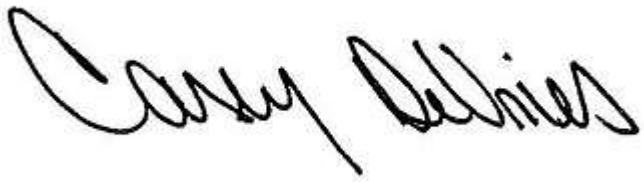
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey/a complaint investigation. 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: SL36561015 On October 6, 2021, through October 8, 2021, 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 2 residents receiving services under the provider's Assisted Living license.	0 000	SL36561015 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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	
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's record included an unsigned service plan dated October 7, 2021, indicated R1 was admitted May 1, 2021, and received copy of the Minnesota Home Care Bill of Rights. On October 6, 2021, at approximately 11:00 a.m., during tour of facility, Home Care Bill of Rights dated November 2019 was posted on a wall in the common area for all residents to access. On October 7, 2021, at approximately 11:00 a.m., during interview, R1 stated they received BOR, "a long time ago, but it is on the wall over there,"	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 450	Continued From page 2 and pointed to outdated Home Care BOR posted on wall in common area. On October 8, 2021, at approximately 11:00 a.m., registered nurse (RN)-A acknowledged an outdated Home Care BOR was posted and provided to all residents. RN-A acknowledged licensee was not aware of the current Assisted Living BOR dated May 16, 2021, therefore, it was not provided to any residents. The licensee's Protecting Resident Rights policy dated August 1, 2021, identified all required content for Minnesota Statute 144G.41 subd. 1. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3 Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated October 6, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by:	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 4 Based on observation, interview and record review, the licensee failed to ensure an allegation of alleged maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) timely for one of one resident (R1) with record 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 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 record included Possible Abuse form dated September 24, 2021, at 7:00 a.m., completed by registered nurse (RN)-A. The document indicated R1 had engaged in abuse toward self as evidenced by R1 self-reported to the licensee having had recently engaged in prostitution of self, drinking, and using unknown substance while at a hotel. The form indicated R1 stated they, "had to prostitute," as they needed money. R1's record included form Assessment by Date completed by RN-A dated September 1, 2021, indicated R1 had a risk to abuse themselves with interventions to include 1:1 time with staff, and to contact nurse if self-abuse was reported by R1. Additionally, assessment indicated client (resident) denied alcohol use, a history of abusing clonazepam (a controlled medication classified as a benzodiazepine), and R1 has, "difficulty weighing advise - has impaired judgment," but lacked interventions to be taken to address the	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 5 safety concerns. R1's record included an Individual Abuse Prevention Plan (IAPP) completed by RN-A dated October 6, 2021. Software system used by licensee pulls same data from R1's Assessment by Date; therefore, indicated R1 had a risk to abuse themselves with interventions to include 1:1 time with staff, and to contact nurse if self-abuse was reported by R1. Additionally, IAPP indicated client (resident) denied alcohol use, a history of abusing clonazepam (a controlled medication classified as a benzodiazepine), and R1 has, "difficulty weighing advise - has impaired judgment," but lacked interventions to be taken to address the safety concerns. On October 6, 2021, at approximately 11:00 a.m., during entrance conference, RN-A stated they knew the requirements for reporting maltreatment, abuse, and neglect of vulnerable adults to MAARC. On October 8, 2021, at approximately 12:15 p.m., RN-A stated, "We [Owner (O)-C and RN-A] discussed reporting it, but since no harm came to her, we just did the incident report [referring to Possible Abuse form]. I should have sent it." The licensee's Vulnerable Adults and Maltreatment - Communication, Prevention, and Reporting policy dated January 1, 2020, and Vulnerable Adults training policy dated November 15, 2019, contained all requirements for reporting to MAARC and to address Minnesota Statute 144G.42 subd. 6. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 6 days	0 620		
0 630 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to identify a specific intervention for each known vulnerability and failed to update the individual abuse prevention plan after an incident indicated a new vulnerability and the risk of causing harm to self for one of one resident (R1) with record review. 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 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:	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 7 R1 admitted on May 1, 2021. R1's Service Plan printed for surveyors October 7, 2021, indicated R1 received medication administration, behavior management for agitation, anxiety, repetitive behavior, depression, paranoia and other mental health needs in addition to other activities of daily and weekly assistance such as room cleaning, bed making and laundry. R1's record included MN Department of Human Services Community Support Plan (CSP) dated January 8, 2021, indicated, "[R1] has concerns that she has the access to medications that could be harmful to her if taken in excess. She doesn't always trust herself when she is struggling emotionally and worries that she may misuse her medication." R1's record included a form titled, Assessment by Date, completed by registered nurse (RN)-A on September 1, 2021. The form indicated, "Med Self-Admin is not applicable [sic] Client admitted to not following doctors order when taken [sic] her medications therefore client will have staff to fully assist with all medications," and "Needs help taking medications (Med admin) Staff will administer all MD ordered medications." Licensee's record titled Possible Abuse- [R1] 09/24/2021 07:00 AM, authored by registered nurse (RN)-A on September 28, 2021 indicated R1 called RN-A for a ride back to the facility during a leave of absence (LOA) from the facility at a hotel. The document indicated that R1 told RN-A that she, "had to prostitute" for money and that R1 had been drinking and using an unknown substance. R1's Progress note by unlicensed personal	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 8 (ULP)-B dated September 28, 2021, indicated, "CEO, Nurse, and staff had a sit-down conversation about the fentanyl being in her system. AL said she didn't know she had it in her system until her treatment did a [urinalysis] ua," indicated R1 used fentanyl (a highly addictive narcotic medication) not included in current prescribed medications. R1's record included untitled form unlicensed personnel (ULP)-B called, "Leave of Absence Form," dated September 30, 2021, indicated R1's meds were set up and sent with R1 for a leave of absence from October 1, 2021, through October 4, 2021 to include Gabapentin 400mg twice a day and Belbuca Mis 450mg every 12 hours for pain, Desvenlafax 150mg once a day for depression, Lithium 150mg once a day for bipolar disorder, and Olanzapine 10mg twice a day and 20mg once a day. Medications on form included all scheduled medications to be self-administered by R1 while on leave. R1's record included a form titled, Med Admin Summary - Month, dated September 2021, indicated medications were sent on pass for 20 out of 30 days during the month. R1's progress note by ULP-B dated October 1, 2021, at 3:04 p.m. indicated, "She (R1) will be with [male name] for the weekend. Staff texted back saying just let us know when you will be home to pick up her meds." R1's progress note by ULP-D dated October 3, 2021, at 7:19 a.m. indicated, "[R1] was out of the facility for the weekend" R1's Individual Abuse Prevention Plan (IAPP) printed for surveyors, October 6, 2021, indicated	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 9 R1, "Needs help taking Medications (Med Admin): Staff will administer all MD ordered medications," and "Drug use and/or history of use, including the resident's drug use not prescribed: Client admitted to overusing clonazepam for abuse purposes and medications is now discontinued." On October 7, 2021, at approximately 11:45 a.m., observed ULP-B pack medications per R1 request for a leave of absence for the evening with a friend. On October 7, 2021, at approximately 11:00 a.m., Owner (O)- C stated R1 is sent on leave of absence with medications set up by staff for R1 to self-administer. RN-A acknowledged R1 does self-administer the medications that are set up by staff. ULP-B stated the medications for "4's and 5's," were for R1 to go out with a friend the evening of October 7, 2021, but R1 would return before the 8:00 p.m. medications were due for administration. On October 8, 2021, at approximately 12:30 p.m., RN-A stated a reassessment was completed on September 24, 2021, but the licensee's electronic health record system produced an error when access to the assessment was attempted. The licensee failed to re-assess and identify specific interventions to R1's newly identified vulnerabilities following R1's admission of participating in prostitution and consumption of alcohol and unknown substances in addition to R1's pre-packaged scheduled medication consumption while away from the facility. TIME PERIOD FOR CORRECTION: Immediate. October 11, 2021, immediacy removed as	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 10 confirmed by on-site observations by surveyor on October 8, 2021 and document review/phone conversation between RN-A and evaluation supervisor on October 11, 2021.	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (ULP-B) with employee 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 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: Unlicensed personal (ULP)-B's record lacked documentation of a completed background study. ULP-B had a start date of July 30, 2021. On October 7, 2021, at approximately 11:45 a.m., observed packing medications to be provided to R1. On October 7, 2021, ULP-B provided evidence of background study clearance dated October 7, 2021. On October 8, 2021, at approximately 4:00 p.m., registered nurse (RN)-A acknowledged no documented background study prior to ULP-B providing cares was included in ULP-B's record. RN-A stated one was completed on ULP-B's date of hire, but was unsure why the original background study was not included.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 12 The licensee's Employee Records policy dated August 1, 2021, indicated all required content related to Minnesota Statute 144G.42 subd. 8. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 13 by: Based on observation and interview, the licensee failed to ensure smoke alarms were provided on each story of the home. The licensee also failed to ensure smoke alarms were clean and updated. This had the potential to directly affect all two residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 building tour on October 7, 2021, with owner (O)-C, the surveyor observed there was no smoke alarm on the main level. The main level included the kitchen, mechanical closet, dining room, living room with double height space and lofted bedroom above. The smoke alarm in the basement hallway, across from the laundry area was also dirty and expired. O-C confirmed the facility lacked smoke alarms on the main level of the home and the basement smoke alarm needed to be replaced. The lofted bedroom upstairs had an inaccessible loft and no smoke alarm was visible in lofted area. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information provided.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: Upon approach to facility on October 7, 2021, the surveyor observed chicken wire installed under the front deck of the building, which was directly outside bedroom #3's egress window. During building tour, owner (O)-C explained the chicken	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 15 wire had been installed by the housing association to reduce the amount of litter collected under the front deck of the town houses. In case of fire or emergency, resident would become trapped under the front deck if exiting from bedroom #3 egress window. O-C also explained R2 had broken the egress window, and it had not been repaired yet. Due to quantity of personal belongings and furniture in front of the window, surveyor could not open the blinds to confirm to what extent egress window was damaged. During the building tour on October 7, 2021, with O-C, the surveyor observed multiple cover plates missing from outlets and light switches throughout the house, including in resident rooms. Upon plugging in a power chord for surveyor laptop in the living room next to the TV, a spark was observed. The light switches in each bedroom of the basement lacked cover plates, and there were no overhead lights. O-C explained that the light switches controlled outlets in the rooms. Each resident must provide a lamp to have artificial light. Neither room in basement had a lamp; therefore, the surveyor could not confirm whether electricity was turned on and working correctly. Light switch in bedroom #3 did not appear to stay in the on position. During the building tour on October 7, 2021, with O-C, the surveyor observed the ceiling in bedroom #2 had a portion missing, approximately 24 inches by 36 inches in size. Duct work was exposed and drywall was hanging against wall from the ceiling. O-C explained bedroom #2 was currently unoccupied, and due to replacing the water heater earlier in the year, they had to open the ceiling. She did not know when the ceiling would be repaired.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 16 The licensee lacked documentation for a maintenance plan or schedule for repairs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 17 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This has the potential to affect the licensee's two (2) residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 7, 2021, the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules and logs, if available. Owner (O)-C stated she did not have a training plan or policy for residents or staff, and did not have any evacuation drills planned or completed. O-C provided outline policy from third party developer for fire safety, evacuation plan, fire drills. The policy had not been developed or implemented for this specific facility. No additional information provided.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 19 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 ensure the assisted living contract included a signature or other authentication by the resident and the facility for one of one resident (R1) 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, 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 Assisted Living Contract, dated March 1, 2021, lacked a signature or other authentication by the resident and by the facility. On October 8, 2021, at approximately 4:00 p.m., registered nurse (RN)-A acknowledged there was no signature page for the assisted living contract included in R1's record. RN-A stated one was completed at date of admission but was unsure what happened to the page. The licensee's Contents of Signing an Assisted Living Contract policy, dated August 1, 2021, noted when a prospective resident decides to move into the facility an assisted living contract is signed.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01620 SS=G	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a change of condition reassessment when a resident	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 21 presented with new or changed symptoms for one of one resident (R1) with record reviewed. 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 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 record indicated R1 had a change of condition related to alcohol use, substance use, and placing self in a dangerous situation as a vulnerable adult. R1 ' s record lacked a full head to toe assessment including physical and cognitive assessment based on change in condition of R1. R1 admitted May 1, 2021. R1 ' s Service Plan dated October 7, 2021, indicated R1 received medication administration, behavior management for agitation, anxiety, repetitive behavior, depression, paranoia and other mental health needs in addition to other activities of daily and weekly assistance such as room cleaning, bed making and laundry. R1's record included MN Department of Human Services Community Support Plan (CSP) dated January 8, 2021, indicated, "[R1] reports that she was pulled into prostitution and trafficking others into prostitution at a young age. She reports having a child with her pimp, and eventually lost custody of her daughter due to her chemical use and lifestyle. [R1] reports she was convicted of	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 22	01620		

human trafficking and was in prison for 3.5 years." Additionally, "[R1] has concerns that she has the access to medications that could be harmful to her if taken in excess. She doesn't always trust herself when she is struggling emotionally and worries that she may misuse her medication."

R1's most recent assessment completed by registered nurse (RN)-A dated September 1, 2021, indicated, "Resident is at risk to abuse themselves, specify measures to minimize risk: Client has a history and will voice this to staff who will then contact the nurse ASAP at [Nurse Phone Number] Staff should have 1:1 time with client daily to discuss thoughts, Keep regular scheduled appointment with psychiatry If have thoughts of self harm staff should have client call [facility phone number]," and "Alcohol use and/or history of use, including the resident's alcohol use not prescribed: Client denied any alcohol use Staff should encourage client to not use alcohol," and "Drug use and/or history of use, including the resident's drug use not prescribed: Client admitted to over using clonazepam for abuse purposes and medications is now discontinued." R1's assessment lacked review of prostitution history, history of incarceration for human trafficking, and ability to safely self-administer medications while on leave of absence from the facility. The assessment also read, "Med Self-Admin is not applicable [sic] Client admitted to not following doctors order when taken [sic] her medications therefore client will have staff to fully assist with all medications," and "Needs help taking medications (Med admin) Staff will administer all MD ordered medications."

Progress note dated September 20, 2021, by unlicensed personal (ULP)-B read, "Staff told [R1]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 23	01620		

that she and her housemate they [sic] will be at a hotel this weekend [September 24 through September 26, 2021]. Staff told [R1] that staff will be at the hotel by 8 on Monday to take her to treatment."

R1 ' s record included form titled, Possible Abuse, dated September 24, 2021, at 7:00 a.m., indicated R1 had potential abuse toward self and putting self in a dangerous situation as they had been at a hotel and admitted to using, "unknown substance," alcohol, and prostituting self for money. Although the form indicated RN-A reported the self-abuse to R1 ' s providers, no documentation was found in R1 ' s record when the report was made, what information was conveyed, or what the providers response was.

R1's Progress note by unlicensed personal (ULP)-B dated September 28, 2021, indicated, "CEO, Nurse, and staff had a sit down conversation about the fentanyl being in her system. [R1] said she didn't know she had it in her system until her treatment did a [urinalysis] ua," indicated R1 used fentanyl (a highly addictive narcotic medication) not included in current prescribed medications.

R1's record included untitled form unlicensed personnel (ULP)-B called, "Leave of Absence Form," dated September 30, 2021, indicated R1's meds were set up and sent with R1 for a leave of absence from October 1, 2021, through October 4, 2021. Medications on form included all scheduled medications to be self-administered by R1 while on leave.

R1's record included form titled, Med Admin Summary - Month, dated September 2021, indicated medications were sent on pass for 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 24 out of 30 days during the month. R1 ' s record included a form titled, Individual Abuse Prevention Plan (IAPP), dated October 6, 2021, the form indicated, "Alcohol use and/or history of use, including the resident's alcohol use not prescribed: Client admitted to alcohol abuse and 2 bottles of alcohol was [sic] found in room. Staff should encourage client to not use alcohol." Additionally, "care conference needed to coordinate cares, specify: Staff will help coordinate care with case manager, Nurse and Client." R1 progress note by ULP-B dated October 1, 2021, at 3:04 p.m. indicated, "She (R1) will be with [male name] for the weekend. Staff texted back saying just let us know when you will be home to pick up her meds." R1 progress note by ULP-D dated October 3, 2021, at 7:19 a.m. indicated, "AL was out of the facility for the weekend" On October 6, 2021, at approximately 1:00 p.m., RN-A acknowledged a change of condition assessment would be completed if indicated with resident change. Facility owner stated facility occasionally uses hotel stays for deep cleaning of facility and to allow residents a break from roommates. Owner (O)-C stated the facility pays for the stay as a cost of business. RN-A acknowledged resident is provided all medications and food required for the duration of the scheduled stay, and RN and ULPs call to check on resident when there, but no documentation of checks included in record. On October 7, 2021, at approximately 11:45 a.m., observed ULP-B pack medications per R1	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 25 request for a leave of absence for the evening with a friend. On October 7, 2021, at approximately 11:00 a.m., O-C stated R1 is sent on leave of absence with medications set up by staff for R1 to self-administer. RN-A acknowledged R1 does self-administer the medications that are set up by staff. ULP-B stated the medications for "4's and 5's," were for R1 to go out with a friend the evening of October 7, 2021, but R1 would return before the 8:00 p.m. medications were due for administration. On October 7, 2021, at approximately 11:45 a.m., observed ULP-B pack medications per R1 request for a leave of absence for the evening with a friend. On October 7, 2021, at approximately 12:50 p.m., R1 ' s County Case Manager (CCM) stated they were not aware of any hotel passes or incident regarding prostitution or drug use. CCM stated they have been requesting updated information from the licensee to complete R1 ' s records and continue providing funding through the county. On October 8, 2021, at approximately 12:30 p.m., RN-A stated a reassessment was completed on September 24, 2021, but the licensee ' s electronic health record system produced an error when access to the assessment was attempted. RN-A stated a head-to-toe assessment was completed, but no documentation could be produced. ULP-B stated they remembered RN-A assessing R1 on that date when R1 returned to the facility. Form titled, Possible Abuse, dated September 24, 2021, at 7:00 a.m., did not indicate a head-to-toe assessment was completed by RN-A.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 26 The licensee failed to re-assess R1 following R1 ' s admission of participating in prostitution and consumption of alcohol and unknown substances in addition to R1 ' s pre-packaged scheduled medications while away from the facility. This indicated a change of condition from R1 ' s previous assessment, which indicated R1 had a history of but was not currently abusing substances. RN-A failed to complete a comprehensive head to toe assessment to check R1 for physical injury, assess R1 ' s body systems including ensuring R1 ' s vital signs were within normal limits after using prescribed and unknown substances, and whether or not R1 could safely self-administer her medications while away from the facility. Further, RN-A failed to ensure the provided services were appropriate and sufficient to ensure R1 ' s continued safety. TIME PERIOD FOR CORRECTION: Immediate October 11, 2021, immediacy removed as confirmed by on-site observations by surveyor on October 8, 2021 and document review/phone conversation between RN-A and evaluation supervisor on October 11, 2021.	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 27 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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan addendum included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of one resident (R1) 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Service Plan Agreement Addendum, dated October 6, 2021, lacked a signature or other authentication by the resident and by the facility.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 28 On October 8, 2021, at approximately 4:00 p.m., registered nurse (RN)-A acknowledged there was no signature page for the service plan addendum included in R1's record. RN-A stated one was completed at date of admission but was unsure what happened to the page. The licensee's Contents of Service Plans policy, dated August 1, 2021, noted the service plan and any revisions would include a signature or other authentication by the facility and the resident. No further information was provided. TIME PERIOD FOR CORRECTION- Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed re-assessments when there was change in the resident's medications and potential side effects after R1 admitted to usage of non-prescribed drug use for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 29	01710		

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 record indicated R1 had a change of condition related to alcohol and substance use.
R1's record lacked a comprehensive medication review assessment based on change in condition of R1.
R1 admitted May 1, 2021. R1's service plan dated October 7, 2021, indicated R1 received Medication Management Services.
R1's most recent assessment completed by registered nurse (RN)-A dated September 1, 2021, indicated, "Alcohol use and/or history of use, including the resident's alcohol use not prescribed: Client denied any alcohol use Staff should encourage client to not use alcohol," and "Drug use and/or history of use, including the resident's drug use not prescribed: Client admitted to over using clonazepam for abuse purposes and medications is now discontinued."
R1's most recent Individualized Medications Management Plan dated September 1, 2021, indicated, "Med Self-Admin is not applicable [sic] Client admitted to not following doctors order when taken [sic] her medications therefore client will have staff to fully assist with all medications," and "Needs help taking medications (Med admin) Staff will administer all MD ordered medications."
R1's record included form titled, Possible Abuse, dated September 24, 2021, at 7:00 a.m., indicated R1 had admitted to using an "unknown substance" and alcohol. Although the form indicated RN-A reported to R1's providers, no documentation was found in R1's record when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 30	01710		

the report was made, what information was conveyed, or what the provider's response.
R1's Progress note by unlicensed personal (ULP)-B dated September 28, 2021, indicated, "CEO, Nurse, and staff had a sit down conversation about the fentanyl being in her system. [R1] said she didn't know she had it in her system until her treatment did a ua [urinalysis]," indicated R1 used fentanyl (a highly addictive narcotic medication) not included in current prescribed medications.
On October 6, 2021, at approximately 1:00 p.m., RN-A acknowledged a change of condition assessment would be completed if indicated with a resident change. RN-A acknowledged a resident is to be provided all medications based on RN-A's most recent assessment.
On October 8, 2021, at approximately 12:30 p.m., RN-A stated a reassessment was completed on September 24, 2021, but the licensee's electronic health record system produced an error when access to the assessment was attempted. RN-A stated an assessment was completed, but no documentation could be produced. ULP-B stated they remembered RN-A assessing R1 on that date when R1 returned to the facility. Form titled, Possible Abuse, dated September 24, 2021, at 7:00 a.m., did not indicate a Individualized Medication Management Plan assessment was completed by RN-A.
The licensee's Assessment - Schedules policy dated January 1, 2020, indicated, "Type of assessment or monitoring: Ongoing Medication Management Monitoring and Reassessment. Date/Timeframe: When the client presents with symptoms or other issues that may be medications related. Nurse authorized to perform the assessment or monitoring: RN. Location/method where assessment or monitoring is to be conducted: Face-to-Face with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 31 the client. Reference: MN 144A.4792 Subd. 3." The licensee is licensed and operated under Minnesota Assisted Living Statutes 144G, not Home Care 144A as referenced in the policy. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
St. Paul
651-201-4500

Type: Full
Date: *10/06/21*
Time: 15:02:10
Report: 8059211073

Food and Beverage Establishment Inspection Report

Location:
Healing Homes Living Services
83 Cook Ave W St Paul,
MN55117 Ramsey County, 62

Establishment Info:
ID #: N106202
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS FOUND OVER READY-TO-EAT FOODS IN THE REFRIGERATOR.

Comply By: 10/06/21

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

TURKEY WAS FOUND OPENED WITHOUT A DATE MARK.

Comply By: 10/06/21

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

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

NO PROBE THERMOMETER WAS PROVIDED.

Comply By: 10/13/21

2-100 Supervision

2-102.12AMN

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

NO CFPM IS EMPLOYED.

Comply By: 11/03/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

RODENT DROPPINGS FOUND UNDER SINK AND IN UNUSED DRAWERS. CLEAN AND MAINTAIN.

Comply By: 10/13/21

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

All violations on this report were discussed with person in charge, Chikio Richmond.

Chikio Richmond mentioned that they were planning on remodeling the kitchen. I explained to Chikio that they will want to reach out to HRD to discuss if plan review is needed.

The following physical facility items were noted and discussed with Chikio Richmond:
- Vinyl Floor with cracks
- Popcorn ceiling
- Hollow base-cabinets
- Laminate countertop

Establishment does not have a three compartment sink or a sanitizing dishwasher. To meet MN food Code, establishment will need to have a three compartment sink for dishwashing or install a sanitizing dishwasher. Operators will set up a container of bleach water, between 50 - 200 ppm, to sanitize dishes after washing and rinsing.

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 8059211073 of 10/06/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Chikio Richmond
Owner

Signed:_____
James Noyola
Sanitarian Supervisor
St. Paul
651-201-4500
health.foodlodging@state.mn.us