Electronically Delivered

January 10, 2025

Licensee
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN 55112

RE: Project Number(s) SL27183016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 may be 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.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH 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 the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27183016-0 On December 2, 2024, through December 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to handwashing and glove use for one of one unlicensed personnel ((ULP)-A). The deficient practice had the potential to affect residents, employees, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-A was hired on February 18, 2020, as a	0 510		

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0 510	Continued From page 4 resident aide. ULP-A's ADL (activities of daily living) Training Step by Step dated March 22, 2022, indicated R2 had been trained on handwashing, beginning tasks, completion tasks, and apply and remove personal protection gear by the nurse. On December 3, 2024, at 8:25 a.m., the surveyor observed ULP-A assist with medication administration for R4. ULP-A unlocked the medication closet in the kitchen and gathered R4's medications and R4's medication administration record (MAR). ULP-A washed their hands at kitchen sink using soap and water. ULP-A verified the medications to be administered with the MAR while placing the oral medications in a disposable cup. ULP-A gave R4 their Breo Ellipta to self-administer medication and instructed R4 to go to the bathroom to rinse mouth out. ULP-A placed medications in locked medication closet and went to bathroom where R4 was to assist R4 rinse mouth properly. ULP-A and R4 returned to the kitchen table to resume administration of medications. ULP-A did not wash hands after leaving bathroom with R4. ULP-A gave Spiriva inhaler to R4 to self-administer medication. ULP-A donned (put on) gloves without washing hands and administered R4's eye drops in both eyes. ULP-A doffed (took off) gloves without performing hand hygiene immediately after removing gloves. ULP-A proceeded to document on R4's MAR. On December 4, 2024, at 8:56 a.m., the surveyor observed ULP-A assist with medication administration for R2. ULP-A washed their hands at kitchen sink using soap and water. ULP-A unlocked the medication closet and gathered R2's medications, R2's MAR, and a large sharps	0 510		

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0 510	Continued From page 5 container. ULP-A reviewed the MAR while verifying R2's medications needed for administration and placed oral medications to be administered in a disposable medication cup. ULP-A then placed all medications that were not being administered back in the locked medication closet. ULP-A donned gloves without performing hand hygiene. ULP-A assisted R2 with administering Breo Ellipta inhaler, then assisted R2 in the bathroom to rinse mouth after administration of inhaler as instructed on MAR while still wearing same gloves. R2 and ULP-A returned to the kitchen table where ULP-A assisted R2 with administration of Incruse Ellipta inhaler while wearing the same gloves. ULP-A placed a test strip in R2's blood glucometer, wiped R2's finger with alcohol wipe and attempted poking R2's finger without success. ULP-A replaced the needle on R2's lancet and re-attempted to poke R2's finger with success. ULP-A placed a drop of R2's blood on the test strip to check blood glucose level while wearing the same gloves. ULP-A then assisted R2 with administration of Novolog insulin injection while wearing the same gloves. ULP-A then assisted R2 to R2's room where R2's nebulizer machine was. ULP-A placed 1 vial of albuterol in the nebulizer machine and handed to R2 to administer with machine on while wearing the same gloves. ULP-A waited in R2's room sitting on R2's recliner for approximately 10 minutes until the medication was gone. ULP-A walked back to the kitchen with R2 while wearing the same gloves. ULP-A grabbed a plate of food from the microwave used for all residents while wearing the same gloves and placed the plate on the table for R2 to eat. ULP-A gave R2 their oral medications that were set up by R2 in the disposable cup while wearing the same gloves. ULP-A doffed the gloves without immediately	0 510		

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0 510	Continued From page 6 performing hand hygiene and then placed R2's inhalers, insulin, and sharps container back in the locked medication closet. ULP-A then proceeded to wash their hands at the kitchen sink with soap and water. On December 4, 2024, at 10:26 a.m., clinical nurse supervisor (CNS)-D stated they expected staff to be washing hands before donning and after doffing gloves; and staff should perform between each task as appropriate. CNS-D stated the licensee did not have a specific policy regarding handwashing or use of gloves but had planned to discuss this at the licensee's next quality management meeting in January as the licensee was in the process of getting a new policy for this and planned to implement at that time. CNS-D showed the surveyor training they had previously completed with all staff that included procedures for beginning a task, completion of a task, and washing hands. The licensee's undated 2.31 Infection Disease policy indicated the licensee would maintain an infection control program that complied with all set infection control standards. The policy failed to include specific procedures for handwashing and use of gloves when providing care to residents. The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings updated September 2024, on page 129, table 4, indicated recommendations for application of standard precautions for the care of all patients in all healthcare settings included the following: - Hand hygiene recommendations after touching blood, body fluids, secretions, excretions,	0 510		

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0 510	Continued From page 7 contaminated items, immediately after removing gloves, and between patient contacts; and - Personal protective equipment (PPE) gloves recommendations for touching blood, body fluids, secretions, excretions, contaminated items, for touching mucous membranes, and nonintact skin. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=D	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;	0 780		

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0 780	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection between all supplied smoke alarms as required for compliance with Minnesota State Fire Code. Per Minnesota State Fire Code provided egress smoke alarms must be interconnected so that the activation of any alarm will cause all other smoke alarms to sound. This had the potential to affect some 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 4, 2024, from approximately 10:40 a.m. to 11:49 a.m., the surveyor toured the facility with agent/senior program manager (A)-E and director of programs/HR (HR)-H. During the tour, the surveyor asked A-E to open test the smoke alarms to verify interconnection. The smoke alarm in resident sleeping room 5 in the basement did not sound when other alarms were tested, and activation of the alarm in resident sleeping room 5 did not set off any other alarms to sound. The smoke alarm in resident	0 780		

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0 780	Continued From page 9 room 5 was not properly interconnected with other provided smoke alarms in the facility. Surveyor explained to A-E and HR-H that at all smoke alarms must be interconnected and must meet the minimum state fire code standard to comply with Minnesota State Fire Code. TIME PERIOD FOR CORRECTION: Two (2) 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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 10 or has the potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, from approximately 10:40 a.m. to 11:49 a.m., the surveyor toured the facility with agent/senior program manager (A)-E and director of programs/HR (HR)-H. During the tour the surveyor observed the following. An outlet cover was missing from electrical outlets in the living room behind the television, in the lower level office room and in the mechanical room. A sprinkler head was missing the escutcheon plate that is designed to cover the gap between the sprinkler head and the ceiling in the lower level in the hallway near the mechanical room. During the facility tour interview on November 19, 2024, A-E and HR-H verified the above listed physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 11 (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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted on May 28, 2019, with	01620		

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	27183	A. BUILDING: _____ B. WING _____	12/04/2024

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(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 12 diagnoses of schizophrenia and diabetes. R2's Service Plan - IAPP dated February 22, 2024, indicated R2 received services including medication administration, mental health management, and assistance with activities of daily living. R2's record included 90-day nursing assessments dated March 6, 2024, June 5, 2024, and September 5, 2024. The assessment dated June 5, 2024, indicated 91 days had passed since the prior assessment completed on March 6, 2024. The assessment completed September 5, 2024, indicated 92 days had passed since the prior assessment completed on June 5, 2024. R3 R3 was admitted on May 24, 2010, with diagnosis of brain injury. R3's Service Plan - IAPP dated October 17, 2024, indicated R3 received services including medication administration, mental health management, and assistance with activities of daily living. R3's record included 90-day nursing assessment dated March 6, 2024, June 5, 2024, and September 5, 2024. The assessment dated June 5, 2024, indicated 91 days had passed since the prior assessment completed on March 6, 2024. The assessment completed September 5, 2024, indicated 92 days had passed since the prior assessment completed on June 5, 2024. On December 3, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-D stated they are aware of the statue and try to complete the assessments on the 5th of the month or just	01620		

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01620	Continued From page 13 before. On December 4, 2024, at 12:01 p.m., during the exit conference, CNS-D stated the licensee planned to complete the assessments every 70 days going forward. The licensee's undated 3.21 Resident Assessment policy indicated the director of nursing (DON) would re-assess the resident every 90 days and complete the uniform assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 14 review, the licensee failed to ensure medication administration was documented accurately in the medication administration record (MAR) for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted on May 28, 2019, with diagnoses of schizophrenia and diabetes. R2's Service Plan - IAPP dated February 22, 2024, indicated R2 received services including medication administration, mental health management, and assistance with activities of daily living. R2's medication administration record (MAR) dated December 2024, indicated the following medications were to be administered at 08:00 a.m. every day: citalopram 20 mg, lisinopril 5 mg, meloxicam 15 mg with food, vitamin D3 2,000 units (iu), acetaminophen 1000 mg, metformin 1000 mg, Breo Ellipta one puff, Incruse Ellipta one puff, polyethylene glycol (generic MiraLAX) 17 grams (g), Albuterol nebulizing solution one vial, and Novolog Flex pen three units. The surveyor observed R2 getting their 08:00 a.m. medications on December 3, 2024, starting at 9:25 a.m.; and on December 4, 2024. starting at	01760		

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01760	Continued From page 15 8:56 a.m. R2's MAR dated November 2024 and December 2024, indicated R2 could have Ventolin HFA two puffs every four hours as needed for shortness of breath. R2's MARs indicated the Ventolin inhaler had not been administered in the months of November 2024 and December 2024. On December 3, 2024, at 8:41 a.m., unlicensed personnel (ULP)-G stated R2 was still sleeping due to being up all night and that was why they did not administer R2's medications earlier. On December 3, 2024, at 9:25 a.m., the surveyor observed unlicensed personnel (ULP)-A administer 8:00 am scheduled medications for R2. ULP-A washed their hands at the kitchen sink with soap and water and then gathered R2's medications, glucometer, and R2's MAR from the locked medication closet. ULP-A verified R2's medications with R2's MAR. ULP-A noted Albuterol nebulizing solution on the MAR but could not find the medication. ULP-A asked ULP-G about this medication, ULP-G went into locked medication closet and grabbed R2's Ventolin inhaler. ULP-A poured MiraLAX powder into a disposable medication cup and stated it had measured 17 g. The surveyor observed the medication to be less than 17 g and the disposable measuring cup did not indicate where 17 g would be measured. ULP-G instructed ULP-A to re-measure the amount using the MiraLAX bottle cap to measure the 17 g to the white section in the cap as indicated on the MiraLAX bottle under directions. ULP-A poured the MiraLAX powder in the cap to the white line and then gave this to ULP-G to mix with 8 ounces of hot water for cocoa. ULP-A completed review of R2's MAR and prepared R2's medications for	01760		

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01760	Continued From page 16 administration. ULP-A placed R2's medications that were not going to be administered back in the locked closet and the medications to be administered on a cart with R2's glucometer and needles for insulin and lancet. ULP-A went to R2's room and knocked on door as they instructed R2 it was time for their medications. ULP-A went into the room and then stated to R2 they would be right back. ULP-A left the medication cart with R2's medications to be administered, R2's insulin and supplies, and R2's inhalers in the room with R2. ULP-A went to the locked medication closet in the kitchen area to get a sharps container. During this time, ULP-G asked ULP-A what they were doing, and ULP-G then proceeded to R2's room. ULP-A returned to R2's room with a sharps container. ULP-A donned gloves without using hand hygiene. ULP-A cleaned R2's finger with alcohol wipe and then poked R2's finger to gather a drop of blood for the glucometer to get blood glucose result of 311. ULP-A gave R2 their Novolog insulin pen and a new needle for the pen. R2 placed the new needle on the insulin pen. ULP-G instructed R2 not to forget to prime the insulin pen. ULP-A instructed R2 to prime with three units, which should have been two units per R2's MAR instructions. ULP-A assisted R2 with holding their shirt up to clean a spot for the injection on abdomen. ULP-A wiped area on abdomen for injection and verified the dose on the insulin pen was set to three units. R2 self-injected the insulin. ULP-A gave R2 their Ventolin inhaler to self-administer without shaking the inhaler well. R2 inhaled one puff which should have been two puffs per R2's MAR instructions. ULP-A looked at ULP-G and asked if they needed to rinse mouth. ULP-G stated to do this after all the inhalers were given. ULP-A then gave R2 their Breo Ellipta inhaler to self-administer. R2 inhaled one puff.	01760		

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01760	Continued From page 17 ULP-A then gave R2 their Incruse Ellipta inhaler. R2 inhaled one puff. ULP-G assisted R2 to the bathroom to rinse mouth while ULP-A placed 1 vial of albuterol solution in R2's nebulizer machine. ULP-G and R2 returned to R2's room. ULP-A gave R2 their oral medications in the disposable cup with a glass of water. ULP-A observed R2 taking the oral medications. ULP-A gave R2 their nebulizer mouthpiece and turned-on machine to administer albuterol nebulizer solution. ULP-A observed R2 for the duration of the nebulizer treatment. ULP-A turned off the nebulizer machine once the solution was all gone. ULP-A and R2 then walked to the kitchen table where ULP-G provided R2 with four cinnamon raisin toast and coffee with the MiraLAX powder. ULP-G stated if they had put the MiraLAX in water, then [R2] would not drink it. ULP-A unlocked medication closet and gathered R2's MAR. ULP-A documented medications administered in R2's MAR by picking up each medication and then placing their initials by each medication listed on the MAR. The surveyor observed ULP-A grab Ventolin inhaler and then initial under albuterol nebulizer to indicate this was administered. The surveyor did not observe ULP-A documenting under Ventolin inhaler on the MAR. The surveyor observed ULP-A document under MiraLAX to indicated they had administered the MiraLAX but this was not completely consumed by R2 and was not administered by ULP-A as ULP-G gave this prepared medication to R2. ULP-A verified they had completed their documentation of the medications administered with surveyor. The surveyor asked ULP-A about the administration of the Ventolin inhaler listed as an as needed medication for R2 and stated this was not documented as given on R2's MAR. ULP-G stated the Ventolin inhaler was given due to R2	01760		

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01760	Continued From page 18 struggling to breathe and that was why they gave that medication to R2. The surveyor did not observe R2 requesting the as needed medication during the observation of the medication administration for R2's scheduled medications. The surveyor then observed ULP-A document on R2's MAR that the as needed Ventolin inhaler was administered and indicated the reason. The surveyor observed R2 sitting at the table eating their toast and still drinking their coffee with the MiraLAX that was given by ULP-G. On December 4, 2024, at 12:16 p.m., clinical nurse supervisor (CNS)-D stated they would complete a medication error and provide retraining. The licensee's 3.6 Medication Management policy indicated direct care staff administering medications are taught not only to pass the medication but to observe the client while taking them. The licensee did not have a policy and procedure as required for preparing and giving medications; verifying that prescription drugs are administered as prescribed; and documenting medication management activities. The manufacturer's instructions for Ventolin HFA dated April 2024, indicated if the inhaler had not been used within fourteen days or if the inhaler had dropped then the inhaler would need to be primed by shaking the inhaler and spraying the inhaler four times into the air away from the face. The manufacturer's instructions also indicated the inhaler should be shaken well prior to administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 19 days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of three residents (R2) with medication management services; and failed to monitor a medication refrigerator to ensure temperatures were maintained according to the manufacturer's instructions for one of one resident (R2) with medications stored in medication refrigerator. 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: STORAGE On December 3, 2024, at 9:25 a.m., during an observation of medication administration for R2, the surveyor observed ULP-A went to R2's room and knocked on door as they instructed R2 it was	01880		

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01880	Continued From page 20 time for their medications. ULP-A went into the room and then stated to R2 they would be right back. ULP-A left the medication cart with R2's medications to be administered on the cart, R2's insulin and supplies, and R2's inhalers in the room with R2. ULP-A went to the locked medication closet in the kitchen area to get a sharps container. During this time, ULP-G asked ULP-A what they were doing, and ULP-G then proceeded to R2's room. ULP-A returned to R2's room with a sharp's container and proceeded to administer medications for R2. REFRIGERATOR On December 3, 2024, at 8:18 a.m., the surveyor observed a locked medication refrigerator located in a common kitchen area. The surveyor opened the refrigerator and observed the thermostat inside the refrigerator read at 30.1 degrees (°) Fahrenheit (F). The surveyor observed unopened resident insulin pens (an insulin delivery system resembling a large pen) stored in the medication refrigerator as followed: - R2's nine unused basaglar kwikpen 100 units (u)/milliliter (ml) x; and - R2's eight unused insulin aspart flex pen (generic for Novolog) 100u/ml. On December 3, 2024, at 11:04 a.m., the surveyor observed the locked medication refrigerator located in a common kitchen area. The surveyor opened the refrigerator and observed the thermostat inside the refrigerator read at 34.7° F. Also, ULP-A and ULP-G observed the temperature and noted the thermostat read 34.7° F as well. On December 5, 2024, at 10:03 a.m., the surveyor observed the locked medication refrigerator located in a common kitchen area.	01880		

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01880	Continued From page 21 The surveyor opened the refrigerator and observed the thermostat inside the refrigerator read at 35.2° F. Also, ULP-A observed the temperature and noted the thermostat read 35.2° F as well. On December 3, 2024, at 8:58 a.m., clinical nurse supervisor (CNS)-D stated if the medication refrigerator temperature was out of range, the staff should have called the nurse right away. The licensee's temperature log for November and December, indicated the refrigerator temperature range should be between 36° F and 41° F; and if it is outside of these parameters, the nurse/SPM are to be notified. The temperature log indicated on November 17, 2024, the temperature was documented at 34° F; on November 26, 2024, the temperature was documented at 32.7° F; on November 27, 2024, the temperature was documented at 31.5° F. The temperatures were not within the specified range as directed on the licensee temperature log; and the licensee did not have any record of corrected temperatures documented for the days the refrigerator was out of range. On December 4, 2024, at 11:16 a.m., CNS-D stated the new thermoset was reading at 36.5° F, and stated they planned to do further teaching with staff. The licensee's 3.6 Medication Management policy indicated the DON (director of nursing) would create a medication management plan that included storage of medications based on resident's need. The licenses did not have a policy and procedure on controlling and storing of medications as required.	01880		

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01880	Continued From page 22 The manufacturer's instructions for Novolog flex pen (insulin aspart) revised February 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for Basaglar Kwikpen revised November 2023, indicated to store unused Pens in the refrigerator at 36 degrees F to 46 degrees F and not to use if the pen had been frozen. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *12/02/24*
Time: 12:40:41
Report: 1021241369

Food and Beverage Establishment Inspection Report

Location:
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0038731
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634327228
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

INTERIOR OF THE VENTILATION HOOD AND FILTER CONTAINS ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 12/06/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SHREDDED CHEESE - WHIRLPOOL REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 40 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Type: Full
Date: *12/02/24*
Time: 12:40:41
Report: 1021241369
Scenic Hills Alternative Care

Food and Beverage Establishment Inspection Report

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH SENIOR PROGRAM MANAGER, CRYSTAL PLAGENS AND HEALTH REGULATION DIVISION NURSE EVALUATOR, RHAWNIE QUINEHAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, VINYL FLOORS AND POPCORN CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021241369 of 12/02/24.

Certified Food Protection Manager: CRYSTAL A. HOWARD

Certification Number: FM64664 Expires: 10/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

CRYSTAL PLAGENS
SENIOR PROGRAM MANAGER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us