Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 12, 2024

Licensee
Nuvision Homecare Services LLC
4568 Zenith Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37102015

Dear Licensee:

On March 28, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 22, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 22, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 22, 2023, found not corrected at the time of the March 28, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) - $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on March 28, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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.

IMPOSITION OF FINES:

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.

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.

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

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.

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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

Sincerely,

Bob Dehler, P.E.
Engineering Manager

Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710 Fax:1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	R 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37102015-1 On March 27, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 22, 2023. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	{0 650}		

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{0 650}	Continued From page 1 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. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	{0 660}		

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{0 660}	Continued From page 2 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 660}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors.	{0 790}		

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{0 790}	Continued From page 3 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: On March 27, 2024, at 11:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-F and unlicensed personnel (ULP)-E. During the facility tour, it was observed the fire extinguishers on all levels did not have a service tag showing they had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. On March 27, 2024, at 11:30 a.m., LALD-F verified maintenance had not been completed as required on fire extinguishers in the facility.	{0 790}		
{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	{0 800}		

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{0 800}	Continued From page 4 by: Based on observation and interview, the licensee failed to maintain 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 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 27, 2024, at 11:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-F and unlicensed personnel (ULP)-E During the facility tour, survey staff observed the following items: On the patio, it was observed burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. It was observed that the wall-mounted handrail at the stair on the main level was not securely anchored to the wall, and the handrail was loose. On the stairs to the lower level, it was observed that stair noses were severely damaged and cracked with sharp edges. In the laundry room on the lower level, it was observed that the multiple plug strips were	{0 800}		

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{0 800}	Continued From page 5 daisy-chained with an extension cord feeding off one of the plug strips to provide power to the freezer. The plug strips were attached by a multi-tap plug device, and all these elements created a fire hazard. In the living room on the lower level, the ceiling tile was damaged and sagged. In the resident's bedroom #4 on the lower level, it was also observed that the window well was 49 inches in height from the bottom of the well, but the window well did not have the required vertical ladder installed to meet the egress route requirement. Survey staff explained to LALD-F that window wells deeper than 44" must have permanent steps or a ladder that does not impede the opening of the window. On March 27, 2024, at 11:30 a.m., LALD-F verified these hazard items while accompanying the tour.	{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	{0 810}		

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{0 810}	Continued From page 6 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements. 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, 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:	{0 810}		

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{0 810}	Continued From page 7 On March 27, 2024, at 11:30 a.m., LALD-F provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. It was observed that the fire safety and evacuation plan was not posted on the lower level. It was observed that the posted emergency evacuation plans on the main and upper levels did not show the location and number of resident rooms. During the interview on March 27, 2024, at 11:30 a.m., LALD-F confirmed the posted evacuation plans did not show the location and number of resident rooms, and the evacuation plan was not posted on the lower level.	{0 810}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	{01290}		

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{01290}	Continued From page 8 This MN Requirement is not met as evidenced by: No further action needed.	{01290}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	{01470}		

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{01470}	Continued From page 9 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	{01470}		

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{01470}	Continued From page 10 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01470}		
{01490} SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: No further action needed.	{01490}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	{01500}		

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{01500}	Continued From page 11 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	{01500}		

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	37102	A. BUILDING: _____ B. WING _____	R 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(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
{01500}	Continued From page 12 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	{01530}		

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{01530}	Continued From page 13 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01530}		
{01760} SS=D	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: No further action needed.	{01760}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	{01890}		

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{01890}	Continued From page 14 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action needed.	{01890}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action needed.	{01970}		

Electronically Delivered

February 27, 2024

Licensee
Nuvision Homecare Services, LLC
4568 Zenith Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37102015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 22, 2023, 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.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH 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 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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

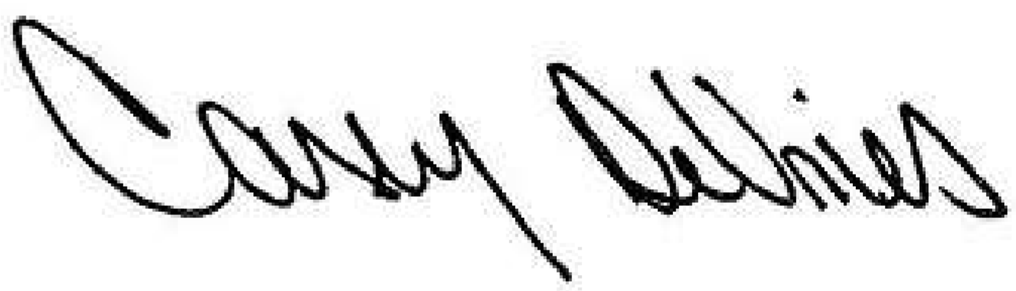
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37102015-0 On December 18, 2023, through December 22, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were four active residents; all four of whom received services under the Assisted Living license. An immediate correction order was identified on December 19, 2023, issued for SL37102015-0, tag identification 1290. On December 20, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on December 19, 2023, issued for SL37102015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On December 20, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000		
0 650 SS=F	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (house manager (HM)-B, unlicensed	0 650		

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0 650	Continued From page 2 personnel (ULP)-D) 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 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: HM-B HM-B started employment with the licensee on January 4, 2021. HM-B's employee record contained a job description dated July 27, 2021, for the position of Home Health Aide. HM-B's employee record lacked a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision for their current position of house manager. HM-B's employee record contained an annual performance review dated December 12, 2023, which indicated the review was for fiscal year 2023. The review indicated HM-B's position held was "Client Services Manager". ULP-D ULP-D started employment with the licensee on October 29, 2021. ULP-D's employee record lacked a job	0 650		

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0 650	Continued From page 3 description including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-D's employee record contained an annual performance review dated December 12, 2023, which indicated the review was for fiscal year 2023. The review indicated ULP-D's position held was "Home Health Aide". On December 22, 2023, at 3:00 p.m., licensed assisted living director (LALD)-F stated the house manager position was not a formalized position yet, and the licensee had not developed a job description for it. LALD-F also stated all staff should have a current job description in their records and agreed to provide them to the surveyor via email by the end of the day on December 26, 2023. The licensee did not email the surveyor job descriptions. Licensee's policy titled Staff Orientation and Education dated August 1, 2021, indicated upon hire, orientation topics would include a review of the employee's job description and responsibilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 4 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of two employees (unlicensed personnel (ULP)-D), training for one of two new employees (ULP-D), and annual education for two of two employees (house manager (HM)-B and ULP-D). 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: On October 22, 2023, the licensee completed a Facility TB risk Assessment that indicated their	0 660		

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0 660	Continued From page 5 risk level to be low for TB transmission. ULP-D was hired on October 29, 2021, to provide direct services to residents. HM-B was hired on January 4, 2021, to provide direct services to residents. TB TESTING ULP-D's employee record contained a chest x-ray that was completed on March 31, 2021; however, ULP-D did not begin employment with the licensee until October 29, 2021. The time from ULP-D's baseline chest x-ray to hire date exceeded 90 days. On December 20, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-A and house manager (HM)-B stated they thought a chest x-ray up to six months prior to hire met the requirements. TB TRAINING ULP-D's employee record lacked TB training on hire and annually for 2022 and 2023. HM-B's employee record lacked annual TB training for 2023. Licensed assisted living director (LALD)-F was out of state for most of the survey. On December 22, 2023, at 3:00 p.m., LALD-F agreed to email the surveyor any remaining TB documentation that LALD-F or other staff may have been unable to locate in LALD-F's absence. The surveyor gave LALD-F until the end of day on December 26, 2023, to email any documents. No TB testing, screening, or training information was received. On December 22, 2023, at 3:00 p.m., LALD-F stated they had missed assigning some training	0 660		

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0 660	Continued From page 6 that included annual TB training but they had a plan in place to be on track with assigning and monitoring completion of education modules in computer-based education system, EduCare, going forward. The licensee's Tuberculosis Screening/ Prevention policy, dated August 1, 2021, indicated licensee would observe practices recommended related to TB prevention identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 7 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This had the potential to affect all current 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 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: On December 19, 2023, at 11:00 a.m., survey staff toured the facility with house manager (HM)-B and clinical nurse supervisor (CNS)-A. It was observed the fire extinguishers on all levels did not have a service tag showing they had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. It was also observed the installed fire extinguishers in the kitchen and one additional fire extinguisher on the lower level were 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as	0 790		

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	37102	A. BUILDING: _____ B. WING _____	12/22/2023

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NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

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0 790	Continued From page 8 required. On December 19, 2023, at 11:00 a.m., HM-B verified maintenance had not been completed as required, and the two fire extinguishers in the facility were not of the appropriate size. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 with regard to the health, safety, and well-being of the residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 9 The findings include: On December 19, 2023, at 11:00 a.m., survey staff toured the facility with house manager (HM)-B and clinical nurse supervisor (CNS)-A. During the facility tour, survey staff observed the following items: On the patio, it was observed burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. It was observed the wall-mounted handrail at the stair on the main level was not securely anchored to the wall, and the handrail was loose. On the stairs to the lower level, it was observed stair noses were severely damaged and cracked with sharp edges. In the laundry room on the lower level, it was observed multiple plug strips were daisy-chained (connected together in a line) with an extension cord and routed through a wall to serve an adjacent room for TV. The plug strips were attached by a multi-tap plug device, with all these elements creating a fire hazard. On December 19, 2023, at 11:00 a.m., HM-B and CNS-A verified these hazard items while accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 10 (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 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 a fire safety and evacuation plan with the required elements, failed	0 810		

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0 810	Continued From page 11 to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. 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, 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: On December 20, 2023, at 1:00 p.m., house manager (HM)-B and clinical nurse supervisor (CNS)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP and the posted emergency evacuation plans on all levels did not show the location and number of resident rooms. During interview on December 20, 2023, at 1:00 p.m, HM-B confirmed the posted evacuation plans did not show the location and number of resident rooms. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. Provided documentation indicated employee training was conducted on	0 810		

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0 810	Continued From page 12 4/21/23 only, with no further employee training being documented. During interview on December 20, 2023, at 1:00 p.m., HM-B confirmed the facility provided only one fire safety training to employees after hire orientation. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated drills were conducted on 1/17/23 at 10:30 a.m., 6/11/23 at 11:30 p.m., and 4/21/23 at 10:30 a.m. with no further drills being documented. During interview on December 20, 2023, at 1:00 p.m., HM-B verified the licensee failed to provide evacuation drills twice per year per shift and every other month as required and confirmed that there were no further documented drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

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0 820	Continued From page 13 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedroom #4 on the lower level. 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: On December 19, 2023, at 11:00 a.m., survey staff toured the facility with the House Manager (HM)-B and Clinical Nurse Supervisor (CNS)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #4 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 38 inches in height and 18.5 inches in width. The windows did not meet the	0 820	This immediate correction order identified on December 19, 2023, has had the immediacy lifted as of December 20, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 14 minimum requirements for opening height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-B and CNS-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. HM-B verbally confirmed the findings. In the resident's bedroom #4 on the lower level, it was also observed that the window well was 49 inches in height from the bottom of the well, but the window well did not have the required vertical ladder installed to meet the egress route requirement. Survey staff explained to HM-B and CNS-A that window wells deeper than 44" must have permanent steps or a ladder that do not impede the opening of the window. HM-B and CNS-A verbally confirmed the findings. On December 19, 2023, at 1:50 p.m., during the phone interview, survey staff explained to HM-B that an immediate correction order was issued for the above finding. HM-B acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On December 20, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 820		

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01290	Continued From page 15	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license prior to staff providing services for four of five employees (house manager (HM)-B, unlicensed personnel (ULP)-C, ULP-D, ULP-E). 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 potential to affect a large portion or all of the residents). This practice resulted in an immediate order for	01290	On December 20, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	

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01290	Continued From page 16 correction on December 19, 2023, at approximately 5:00 p.m. The findings include: HM-B HM-B started employment with the licensee on January 4, 2021, under the former comprehensive license and started providing assisted living services August 1, 2021. On December 19, 2023, from 8:30 a.m. to 11:00 a.m., the surveyor observed HM-B administer medications to R4, prepare breakfast, and complete house chores. On December 19, 2023, the Minnesota Department of Human Services (DHS) NETStudy2.0 (web-based system used to submit background study requests) indicated a background study was completed for the licensee's health facility identification number (HFID) 37102 during the COVID-19 pandemic and expired on December 31, 2022. ULP-C ULP- C started employment with the licensee on June 22, 2021, under the former comprehensive license and started providing assisted living services August 1, 2021. On December 19, 2023, from 10:30 a.m. to 11:30 a.m., the surveyor observed ULP-C complete house cleaning and assist R3 from lower-level family room to R3's lower-level bedroom. On December 19, 2023, at 3:30 p.m., the surveyor along with clinical nurse supervisor (CNS)-A checked the licensee's NETStudy2.0 account, and ULP-C's name was missing from	01290		

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01290	Continued From page 17 the licensee's roster. On December 19, 2023, the NETStudy2.0 website indicated a background study was completed on June 22, 2021, however it was affiliated with licensee's former comprehensive HFID 35552, which was a closed license, but still active in NETStudy2.0. The background study was completed during the COVID-19 pandemic and expired on December 31, 2022. ULP-C did not have a background study affiliated with HFID 37102. ULP-D ULP-D started employment and began providing assisted living services with the licensee on October 29, 2021. On December 18, 2023, at 3:00 p.m., the surveyor observed ULP-D prepare and administer medications to R3. On December 19, 2023, the NETStudy2.0 website indicated a background study was completed for HFID 35552 the licensee's former comprehensive HFID, which was a closed license, but still active in NETStudy2.0. The background study was completed during the COVID-19 pandemic and expired on December 31, 2022. ULP-D did not have a background study affiliated with HFID 37102. ULP-E ULP-E started employment with the licensee on February 7, 2021, under the former comprehensive license and started providing assisted living services August 1, 2021. On December 19, 2023, at 3:42 p.m., HM-B stated ULP-E typically worked three or four eight	01290		

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01290	Continued From page 18 hour overnight shifts every week, and the last shift ULP-E worked began at 11:00 p.m., on December 15, 2023 and ended at 7:00 a.m., on December 16, 2023. On December 19, 2023, the NETStudy2.0 website indicated a background study was completed for HFID 37102 during the COVID-19 pandemic and expired on December 31, 2022. On December 19, 2023, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help	01290		

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01290	Continued From page 19 section of NETStudy 2.0. The Licensee's Background Studies policy dated January 1, 2023, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees, volunteers, and contractors. The policy also indicated new hires shall not be permitted to interact or provide services to residents prior to receiving an approved background study. In addition, the licensee would maintain completed background studies in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On December 20, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 20 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (house manager (HM)-B and unlicensed personnel (ULP)-D). 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: HM-B HM-B was hired on January 4, 2021, and began to provide direct services to residents on September 13, 2021. On December 18, 2023, at 12:00 p.m., HM-B provided the surveyor with licensee's discharged	01440		

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01440	Continued From page 21 resident roster and current resident roster. The admission dates from both rosters indicated the first resident that moved into licensee's facility was R4 on September 13, 2021. On December 19, 2023, at 9:32 a.m., the surveyor observed HM-B prepare and administer medications for R4. HM-B's undated Staff Supervision Summary indicated a RN supervised HM-B on August 11, 2021, while administering medications and checking a blood glucose level but lacked information about specific resident or interaction with that resident. There were not any residents receiving services from licensee until one month after this date. On December 19, 2023, at 3:30 p.m., HM-B and CNS-A agreed supervision could not have occurred prior to R4 moving in and did not know what the documentation was from or if the date was wrong in the computer system. The record lacked additional documentation of supervision in 2021 or 2022. The next supervision indicated on the summary was on August 29, 2023, the RN documented assessment of competency of medication administration and colostomy bag change. This supervision occurred two years after employee began working for licensee. ULP-D ULP-D was hired on October 29, 2021, to provide direct care services to residents of the facility. On December 18, 2023, at 3:30 p.m., the surveyor observed ULP-D prepare and administer medications for R3. ULP-D's undated Staff Supervision Summary	01440		

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01440	Continued From page 22 indicated a RN supervised ULP-D on December 2, 2021, or thirty-five days after hire, while administering medications but lacked information about specific resident or interaction with that resident. Additional supervision was documented by the RN on December 22, 2021, for medication administration, December 17, 2022, for colostomy bag change, and on December 18, 2023, for medication administration. None of these entries contained specific information about the resident or interaction. On December 18, 2023, 11:00 a.m., during entrance conference clinical nurse supervisor (CNS)-A stated part of their routine of training new ULPs is completing a supervisory visit within thirty days of each new ULP starting work at the facility. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated the RN would provide direct supervision of ULPs performing delegated tasks within thirty days after the ULP began working for the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 23 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 24 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees completed required orientation before providing services for two of two direct care employees (house manager (HM)-B and unlicensed personnel (ULP)-D). 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: HM-B HM-B was hired on January 4, 2021, to provide direct services to residents. HM-B's employee record included an Educare (online training platform) transcript which lacked training for required orientation topics of the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 25 and protection of those rights. ULP-D ULP-D was hired on October 29, 2021, to provide direct services to residents. ULP-D's employee record included an Educare (online training platform) transcript which lacked training for the following required orientation topics: - overview of assisted living statutes; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults; -review of provider policies and procedures; -handling of resident complaints, reporting of complaints, where to report; - principles of person-centered planning and service delivery; and -consumer advocacy services. On December 22, 2023, at 3:00 p.m., licensed assisted living director (LALD)-F stated they must have missed following up on some of the early onboarding. Their plan going forward was to have the new hires complete the online education prior to in office education and clear that the online education is complete before they are scheduled, however, that was not implemented yet. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated that upon hire new employees would attend a general orientation session that would provide education on all required topics and occur prior to completing care with residents. No further information was provided.	01470		

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01470	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for two of two employees (house manager (HM)-B and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM-B HM-B started employment with licensee on January 4, 2021. HM-B's employee file lacked evidence of completing dementia care training in the following topics; - an explanation of Alzheimer's disease and other dementias; and	01490		

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01490	Continued From page 27 - person-centered planning and service delivery. ULP-D ULP-D started employment with licensee on October 29, 2021. ULP-D's employee file lacked evidence of completing dementia care training in the following topics; - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On December 22, 2023, at 3:00 p.m., licensed assisted living director (LALD)-F acknowledged the employee files were missing dementia care training and stated the licensee thought because they did not specialize in dementia care the specific training content was not required. The licensee's Dementia Education policy dated August 1, 2021, indicated the licensee's employees would be knowledgeable in how to provide safe, effective services related to dementia. In addition, all employees would complete training in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery No further information was provided.	01490		

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01490	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 29 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each twelve months of employment for two of two employees (house manager (HM)-B and unlicensed personnel (ULP)-D). 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).	01500		

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01500	Continued From page 30 The findings include: HM-B HM-B began employment with the licensee on January 4, 2021, to provide direct care service to residents. HM-B's employee record lacked the following annual training for 2022: - training on reporting of maltreatment of vulnerable adults; - effective approaches to use to problem solve when working with challenging behaviors; - review of the facility's policies and procedures; and - the principles of person-centered planning and service delivery. HM-B's employee record lacked the following annual training for 2023: - infection control; and - review of the facility's policies and procedures. ULP-D ULP-D was hired on October 29, 2021, to provide direct services to the residents. ULP-D's employee record lacked the following annual training for 2022: -training on reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights; - infection control; - effective approaches to use to problem solve when working with challenging behaviors; - review of the facility's policies and procedures; and - the principles of person-centered planning and service delivery.	01500		

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01500	Continued From page 31 ULP-D's employee record lacked the following annual training for 2023: - effective approaches to use to problem solve when working with challenging behaviors; and - review of the facility's policies and procedures. On December 22, 2023, at 3:00 p.m., licensed assisted living director (LALD)-F stated annual training was missed in 2022, and the leadership team was working on a process for managing annual education. LALD-F stated they would like to require training to be completed by mid-year. Clinical nurse supervisor (CNS)-A stated they would like to see a shorter timeframe for the due date that can be tracked with staff held accountable for not completing. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated the education program would be directed by the CNS and include at least eight hours of education annually. In addition, the policy indicated the education topics will include: - reporting of maltreatment of adults; - review of Assisted Living Bill of Rights; - review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors; and - the principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training for two of two direct care employees (house manager (HM)-B and unlicensed personnel (ULP)-D). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for two of two direct care employees	01530		

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01530	Continued From page 33 (HM-B and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM-B HM-B started employment with licensee on January 4, 2021. HM-B's employee record included 6.75 hours of dementia training in April of 2021, however lacked the required full eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents. HM-B's employee record lacked the required two hours of annual dementia training for 2022. ULP-D ULP-D started employment with licensee on October 29, 2021. ULP-D's employee record included 4.25 hours of dementia training in July of 2023. It lacked eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents. ULP-D's employee record lacked the required two hours of annual dementia training for 2022. On December 22, 2023, at 3:00 p.m., licensed	01530		

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01530	Continued From page 34 assisted living director (LALD)-F stated that since they were not a dementia care facility, they did not realize they needed the full eight hours of dementia training. In addition, LALD-F stated annual training had been missed in 2022 but the licensee had a plan in place to maintain future compliance. LALD-F acknowledged HM-B and ULP-D worked full-time and have both worked more than 160 hours for the licensee. The licensee's Dementia Education policy dated August 1, 2021, indicated the licensee's employees would be knowledgeable in how to provide safe, effective services related to dementia. In addition, all direct care employees would have completed at least eight hours of initial dementia education within 160 working hours of their employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=D	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	01760		

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01760	Continued From page 35 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure documentation included follow up on effectiveness of medications administered to relieve symptoms and meet resident needs for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted on October 1, 2021, with diagnosis of autism. R3's unsigned Service Plan printed on December 18, 2023, indicated R3 received medication management and medication administration three times daily. R3's Medication Administration Record (MAR) dated November 1 through 30, 2023, indicated Melatonin 3 mg tablet was administered on the following dates for sleep: November 11, 12, 15, and 17, 2023. On November 11, 12, and 17, the MAR lacked documentation of responsiveness of R3 to this medication administered to promote sleep.	01760		

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	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 36 R3's Medication Administration Record, dated December 1 through 20, 2023, indicated Melatonin 3 mg tablet was administered on December 1, 2023, for sleep. The MAR lacked documentation of responsiveness of R3 to this medication administered to promote sleep. On December 22, 2023, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated they did not know why staff missed documenting that follow up. CNS-A stated they do not receive an alert from RTasks (documentation software) when follow up for an as needed medication is missed, but the ULPs should always be documenting responsiveness to medications they administer. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered would be documented complete, accurate, and legible in the resident's clinical record. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to remove expired	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 37 medication from availability for use for two of two residents (R1, R2). In addition, the licensee failed to ensure time-sensitive medications were labeled with the date opened and medications were kept in the original containers for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: On December 18, 2023, at 11:45 a.m., the surveyor observed the medication cabinet in the facility kitchen/dining area and observed the following: EXPIRED MEDICATIONS The following medications were on the medication cabinet shelves sorted into plastic bins that included current medications for each individual resident: - R3 albuterol aerosol HFA 90 micrograms (mcg) inhaler expired August 29, 2023;and - R4 albuterol aerosol HFA 90 micrograms (mcg) inhaler expired August 17, 2023; MEDICATIONS NO LONGER IN USE The following medications were not expired but were medications that CNS-A stated were no longer in use by the resident: - R5 naltrexone 50 mg tablets; - R5 buspirone 15 mg tablets;	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 38 - R5 spironolactone 25 mg tablets; - R5 acamprosate calcium 333 mg tablets; and - R5 metformin 500 mg tablets. On December 18, 2023, at 12:15 p.m., CNS-A stated they expected staff to report medications that need to be destroyed. CNS-A stated they also look through the medication cabinet quarterly to check for cleanliness and compliance. The licensee's policy Storage/Control of Medications dated August 1, 2021, indicated all medications would be securely locked in substantially constructed compartments according to the manufacturer's directions. In addition, a licensed nurse would check expiration dates and manage reordering needs when they regularly set up medications in a clearly labeled container based on the resident's medication regimen. The licensee's policy was outdated as the nurse no longer sets up medications for licensee's residents; the medications are punched out of bubble packs by the ULP administering them. The surveyor was not able to locate any updates to the policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(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
01970	Continued From page 39 provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: The licensee failed to maintain up-to-date written or electronically recorded order from an authorized prescriber for treatments and therapies for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted on October 1, 2021, with diagnosis of autism. R3's unsigned Service Plan printed on December 18, 2023, indicated R3 received toileting twice weekly with specific directions that indicated: - staff remove old colostomy supplies and place in bag - clean skin with skin cleanser wipes; - monitor stoma to make sure it is pinkish red and moist and sticks out slightly from skin; - change gloves; - measure stoma and cut colostomy ring to fit stoma; - apply skin prep to skin and allow it to dry before placing new colostomy bag;	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37102	A. BUILDING: _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NUVISION HOMECARE SERVICES LLC	4568 ZENITH AVENUE NORTH CRYSTAL, MN 55422

(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
01970	Continued From page 40 - remove tape and apply to skin; and - place two chloroplast Brava elastic barriers around new colostomy bag to ensure adherence. R3's Provider Contact form contained signed physician orders dated August 28, 2023, the form lacked mention of the colostomy bag, changes, or any related treatment cares. On December 22, 2023, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated they thought there should be treatment orders someplace in the medical record for R3's colostomy. The surveyor gave a timeframe until end of day December 26, 2023, for licensee to find and email orders to the surveyor. No orders were received. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse was responsible for assessing and developing the treatment and/ or therapy service plan for residents. This included obtaining orders or prescriptions for all treatments and therapies. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/19/23*
Time: 14:00:00
Report: 1025231281

Food and Beverage Establishment Inspection Report

Location:
Nuvision Homecare Services Llc
4568 Zenith Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037939
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7638438850
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.

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
Employ a CFPM per licensed establishment; for information, please search "MDH CFPM"
Comply By: 12/19/23

4-300 Equipment Numbers and Capacities
4-301.12C
MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.
Facility does not have a 3 compartment sink or a NSF/ANSI dishwasher, provide a basin for sanitizing dishes which are washed and rinsed in the dishwasher for chemical sanitizing.
Comply By: 12/20/23

5-200A Plumbing: approved materials/design
5-201.11B
MN Rule 4626.1040B Maintain the plumbing system in good repair.
Kitchen sink leaking, water collecting on the laminate below, repair the sink and plumbing
Comply By: 01/05/24

Food and Equipment Temperatures

Process/Item: Ambient
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *12/19/23*
Time: 14:00:00
Report: 1025231281
Nuvision Homecare Services Llc

Food and Beverage Establishment Inspection Report

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

Inspection conducted by MDH Kipping and MDH A Spaulding

Food thermometer available
High temp test available
Chlorine test kit available
Bleach for Food Contact Surfaces available

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher which does not meet the requirements of MN 4626.0506
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone/dedicated handwashing sink

FACILITY
Kitchen has tile floor, laminate countertops, painted wood cabinets, stainless but not smooth cabinet handles, hollow enclosed cabinet bases
Appliances are residential
Replace the cabinet hardware with stainless handles that are completely smooth (without rigids or indents in the back)
Reported no other food storage other than the kitchen and attached pantry

DISHWASHING – NON ANSI/NSF 184
Dishwasher is not marked with label/data plate indicating it reaches an internal contact temperature necessarily for sanitizing (NSF/ANSI 184: Residential Dishwasher). Discussed using the dishwasher to wash and rinse dishes and utensils, and providing a bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:
[…] (5) receptacles that substitute for the compartments of a multicompartment sink.
https://www.nsf.org/consumer-resources/articles/dishwasher-certification

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs

https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

Type: Full
Date: *12/19/23*
Time: 14:00:00
Report: 1025231281
Nuvision Homecare Services Llc

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 1025231281 of 12/19/23.

Certified Food Protection Manager: TBD

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231281

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	12/19/23
No. of Repeat RF/PHI Categories Out	0	Time In	14:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Nuvision Homecare Services Llc	Address: 4568 Zenith Avenue North	City/State: Robbinsdale, MN	Zip Code: 55422	Telephone: 7638438850
License/Permit #: 0037939	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN (OUT)	PIC knowledgeable; duties & oversight		
2	IN (OUT) N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/20/23

Inspector (Signature) Gary King