Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

July 25, 2024

Licensee
Hillcrest Terrace
1507 East 41st Street
Hibbing, MN 55746

RE: Initial License Number 410083
Health Facility Identification Number (HFID) 39299
Project Number(s) SL39299015

Dear Licensee:

On July 1, 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 May 3, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective July 1, 2024.

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

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

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,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division
HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

June 10, 2024

Licensee
Hillcrest Terrace
1507 East 41st Street
Hibbing, MN 55746

RE: Provisional Conditional License Number 410083
Health Facility Identification Number (HFID) 39299
Project Number(s) SL39299015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 8, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - $3,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Hillcrest Terrace a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Hillcrest Terrace is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **Local laws apply:** Hillcrest Terrace will uphold the Minnesota Department of Health's (MDH) Minnesota Clean Indoor Act (MCIAA) amendment effective on August 1, 2019, noting smoking is prohibited in health care facilities and clinics.

    i. The licensee will enforce the facility's existing "Smoking/Vaping" policy dated July 31, 2022. This includes, but is not limited to, all common areas, facility rooms, hallways, stairs, lobby areas, dining areas, elevator, restrooms, and any other enclosed areas.

b. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Hillcrest Terrace is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Hillcrest Terrace is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Hillcrest Terrace. If MDH determines Hillcrest Terrace is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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: SL39299015 On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 38 residents receiving services under the provider's provisional Assisted Living license. Immediate correction orders were identified on April 30, 2024, issued for SL39299015, tag identifications 0110 and 0830. Immediacy wass removed following review by evaluation supervisors on May 1, 2024, however noncompliance remains at a scope and level of two, widespread (F) for tag 0110 and a scope and level of three, widespread (G) for tag 0830.	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). This resulted in an immediate correction order identified on April 30, 2024. The findings include: On April 29, 2024, at 9:25 a.m., during the entrance conference LALD-A was identified as the LALD for the facility. Registered nurse (RN)-B said LALD-A was home with a sick child and not able to come to the facility. On April 29, 2024, at 10:23 a.m., the surveyor and	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 110	Continued From page 2 housing manager (HM)-D reviewed the BELTSS license verification website. HM-D confirmed the BELTSS website did not indicate LALD-A was the LALD for the facility. HM-D stated she was working on her LALD adding she had not finished the required classes. On April 30, 2024, at 8:11 a.m., LALD-A stated she was the LALD for three sites, and "it" (LALD for site) was not "just something to hang on the wall." LALD stated "technically" this site does not currently have an LALD. LALD-A said she (LALD-A) was aware there could be an order written for this issue. LALD-A added HM-D would be the LALD in residence (IN) in the future. LALD-A stated HM-D's LALDIR was taking longer to get then expected. On April 30, 2024, at 9:53 a.m., email confirmation was received from BELTSS representative that LALD-A did not have a permit to practice as a LALD. The licensee's Assisted Living Director policy dated July 9, 2023, noted, the licensee is required to have an Assisted Living Director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS.) No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed based on review by evaluation supervisor on May 1, 2024, however noncompliance remains at a scope and level of two, widespread (F).	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 510	Continued From page 4 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of three employees (unlicensed personnel/ULP-G) during medication administration for R3, R9, R2, R4. In addition, the licensee failed to ensure reusable equipment was cleaned in-between resident use, by two of three employees, (ULP-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HAND HYGIENE On April 30, 2024, at 7:20 a.m., the surveyor observed ULP-G wearing gloves administer R3's morning medication at a table in the dining area. ULP-G returned to the medication room and documented R3's medication as given and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 510	Continued From page 5 removed gloves. The surveyor did not observe ULP-G perform hand hygiene. ULP-G applied gloves and used keys to open up the narcotic box in the medication cart. ULP-G punched out one Ativan (anxiety) one milligram (mg) tablet into a medication cup. ULP-G wrote on the back of the medication card. ULP-G removed levothyroxine 25 micrograms (mcg) (thyroid) from a medication card and placed the medication into the medication cup. ULP-G walked into the dining area and handed the medication cup to R9. ULP-G returned to the medication room and documented R9's medication as given. The surveyor did not observe ULP-G perform hand hygiene. On April 30, 2024, at 7:29 a.m., the surveyor observed ULP-G remove gloves, and apply a clean pair of gloves. The surveyor did not observe ULP-G perform hand hygiene. ULP-G gathered R2's morning medication cards from the medication cart. R2 asked for his "breathing apparatus." ULP-G handed R2 a plastic bag and removed the spacer (device that attaches to mouthpiece of an inhaler to make it easier to use and help medication get into the lungs more effectively) and placed the spacer on the table close to where R2 was seated. ULP-G removed gloves. ULP-G asked R2 if he needed a finger prick (blood sugar test)? ULP-G held a blood sugar meter up to R2's right arm to obtain a blood sugar reading. ULP-G prepared and administered R2's morning medications. ULP-G removed gloves. The surveyor did not observe ULP-G perform hand hygiene prior to preparing and administering R2's medications or after glove removal. On April 30, 2024, at 7:55 a.m., the surveyor observed ULP-G with gloves on prepare R4's	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 510	Continued From page 6 morning oral medications. ULP-G placed Voltaren (pain cream) onto a measuring stick and then put the Voltaren cream onto his right gloved hand and rubbed the cream onto R4's lower back. ULP-G removed gloves. ULP-G dropped the measuring stick on the ground. ULP-G picked up the stick and used an alcohol pad to sanitize the measuring stick. ULP-G applied a clean pair of gloves. The surveyor did not observe ULP-G perform hand hygiene. On April 30, 2023, at 8:40 a.m., ULP-G stated sanitizer is "all over the place" and sanitizer was to be used every time "we" (ULPs) use gloves. ULP-G added he normally does not work the morning shift. ULP-G confirmed hand hygiene was not performed as required. SHARED EQUIPMENT ULP-G On April 30, 2024, at 7:43 a.m., the surveyor observed ULP-G place a blood pressure (BP) cuff on R2's right arm and an SpO2 monitor (monitor blood oxygen level in the blood) on R2's left index finger. On April 30, 2024, at 7:44 a.m., ULP-G removed the BP cuff from R2's arm. ULP-G used a forehead type of thermometer to receive a temperature of 97.8 degrees for R2. ULP-G placed the BP machine under the table (on shelve) and left the BP cuff on the table with the SpO2 monitor and thermometer. The surveyor did not observe ULP-G sanitize the vital sign monitoring equipment prior to or after use. ULP-H On April 30, 2024, at 8:14 a.m., the surveyor observed ULP-H place the blood pressure cuff on R10's upper arm. The surveyor did not observe	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 510	Continued From page 7 ULP-H sanitize the BP cuff prior to use. On April 30, 2024, at 8:34 a.m., ULP-H confirmed he had not sanitized the BP cuff prior to use or after use. On April 30, 2024, at 8:32 a.m., ULP-G stated vital sign equipment should be sanitized "right after" use. ULP-G motioned to where he had placed the BP cuff adding he was going to clean it when he had "a second." ULP-G confirmed the BP cuff had not been sanitized. On April 30, 2024, at 1:09 p.m., registered nurse (RN)-B stated her expectation was equipment should be disinfected in-between use and done after use. RN-B confirmed shared equipment was not sanitized as required. RN-B stated when she removed gloves, she washes her hands and she added, "I would hope" that is occurring. RN-B said if they (ULP) are doing a medication pass, hand sanitizer was appropriate. RN-B confirmed hand hygiene was not performed as required. The licensee's Infection Control policy dated July 12, 2023, noted proper hand washing techniques should be used to protect the spread of infection. Hand washing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. The licensee's Cleaning of Shared Medical Equipment dated July 6, 2023, noted the licensee would implement and maintain processes to ensure all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reused. All equipment must be cleaned immediately if visibly soiled, and immediately after use on resident with	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 510	Continued From page 8 contact precautions regardless of cleaning scheduled. Items routinely shared, which cannot be cleaned between uses, will follow a regular schedule for cleaning and disinfection. Cleaning and maintenance processes will follow manufacturer's recommendations. In the absence of recommendations, clean non-critical medical equipment surfaces with a mild detergent followed by cleaning with a disinfectant. Use protective equipment such as gloves, goggles, and gowns as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 9 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 observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of three employees (unlicensed personnel (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, 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: ULP-E was hired on January 29, 2024, to provide direct care services to the licensee's residents. On April 29, 2024, at 11:20 a.m., the surveyor observed ULP-E take R8's blood pressure, temperature, pulse, and blood oxygen level. ULP-E's record included Assisted Living Orientation Training & Competencies form dated January 29, 2024, which noted: -activities of daily living (ADLs) -bathing assistance -dressing assistance -hair care assistance -hearing aid use and care -nail care assistance	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 10 -oral care assistance -shaving assistance -skin care assistance -toileting assistance. Competency test passed: Y___, N___ or NA (not applicable) /if CNA (certified nursing assistant) blank. Method of training (circle all that apply): blank Date completed: NA/videos. On April 30, 2024, at 3:17 p.m., ULP-E's record was reviewed with registered nurse (RN)-B. RN-B confirmed ULP-E's record was not completed as required. RN-B stated she took notes and would ask human resources about training and review Educare (on-line system) training. On May 1, 2024, at 9:00 a.m., RN-B stated "to be honest with you, I can't say for sure, but I know how I was trained to train, and I am the backup trainer. We (RNs) train on all." RN-B said the RN completing the training must have forgot to sign to form as required. The licensee's Employee Records policy dated July 9, 2023, noted employee records for each person would include verification of completed orientation and annual training and competency testing as required. The licensee's Medications & Treatments-Administration & Delegation policy dated July 12, 2023, noted, written records, signed by an RN, shall be maintained regarding ULP training and competency of delegated of treatments/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: On a facility tour on April 30, 2024, at 9:45 a.m., with maintenance (M)-J, the surveyor made the following observations of facility hazards and disrepair: Cigarette butts were observed on the ground and on top of a plastic bucket cover outside away	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 from the building near the basketball hoop. Cigarette butts were also observed outside on the ground away from the building near exterior exit door number 8. Cigarette butts are required to be discarded in an approved container in accordance with the facility smoking policy. The bottom of the door jamb and sidelight was rusted and deteriorated on exterior exit door number 8. The concrete steps and handrail were deteriorating and have deep pockets in the walking surface causing a trip hazard on the outside landing and stairs at exit door number 8. The ceiling light and exhaust fan was not working in the bathroom of resident room number 274. There was a piece of vinyl base coming off the wall under the window in resident room number 274. The exhaust fan was not working in the bathroom of resident room number 272. The exhaust fan light was not working, and the fan/ light/ heater cover looked like it was melted from heat in the men's employee bathroom. There was a hole in the drywall around the water supply valve for the toilet in the women's employee bathroom. An extension cord was observed routed through wire mold trim from a wall outlet through the suspended ceiling and used as permanent power supply for a television in the lounge/ living room next to the dining room. Extension cords are required to be used as temporary wiring only and	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 13 not routed through walls or ceilings in accordance with manufactures installation instructions. The cover of the radiant electric heater was falling off exposing sharp edges in the lounge/ living room next to the dining room. The toilet water was running continually in the bathroom of resident room 251. The marked exit door latch was broken, and the door would not open in the pedestrian walkway between the single level and two-level building. Exit door latches are required to be maintained in working condition for immediate use at all times. The Pepsi pop machine was plugged into a power splitter with no overcurrent protection in the lower level under the stairs of the 2-story building. Major appliances are required to be plugged directly into the wall outlet or provided with an overcurrent protected power strip. The light bulb and electrical fixture globe were missing exposing the light socket on the wall light over the bed in resident room number 235. Light bulbs and light fixture covers are required to be installed according to fixture manufactures instructions to prevent contact with electrical power. The smoke alarm was not working when tested in resident room 235. Smoke alarms are required to be maintained in working condition. An electrical outlet cover was missing in resident room 245 where the air conditioning unit is plugged in. Electrical outlet covers are required to be maintained installed to prevent contact with electrical wire connections.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 14 The exit door closer was broken in the west stairway on the main floor of the 2-story building. During a facility tour on April 30, 2024, at 10:30 a.m., M-J, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 830 SS=G	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R7). 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). This resulted in an immediate correction order identified on April 30, 2024.	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 830	Continued From page 15 The findings include: On April 30, 2024, at 11:15 a.m., engineering evaluator (EE) reported to the surveyor that during his tour with maintenance (M)-J at approximately 10:15 a.m. on the first floor, he smelled smoke in the general hallway. EE stated the smoke smell was strong by room 264. EE and M-J entered the resident's living area (room 264) and observed a small smoking device, a lighter, and an ash tray that contained three cigarette butts. M-J confirmed smoking had occurred in R7's room, adding smoking in rooms was a "continuous" issue. On April 30, 2024, at 11:22 a.m., the surveyor went to R7's room. The surveyor smelled cigarette smoke and observed smoking paraphernalia in R7's living area. R7 stated she was a smoker and tried to go outside to smoke but added at times she smoked in her bathroom. R7 stated she liked it at the facility, and she would get evicted for smoking in her room. R7 was admitted to the facility on March 26, 2015, with diagnoses including attention deficit hyper disorder (lack of focus, poor time management skills, disorganization, impulsivity, forgetfulness, lack of motivation.) R7's assessment dated March 19, 2024, included: Safe smoking -describe your smoking routine i.e how many per day, where do you smoke. Ask resident to light a cigarette. Observe the process- light it, smoke it, and extinguishing it: ½ pack per day (PPD) -where do you store your smoking materials? In room, on person	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 830	Continued From page 16 -how do you dispose of ashes and cigarette butts? Ash can -does the resident safely use matches (yes/no): n/a -if the resident uses a lighter, is it the disposable type? Yes -does the resident handle the lit cigarette responsibly? Yes -does the resident extinguish the cigarette completely? Yes -are there signs in the apartment of mishandled cigarettes such as burns in carper or furniture? n/a -are there signs of burning on the residents' clothing: no -look in waste baskets- are ashtrays emptied in them (yes/no)? n/a -is the resident able to smoke safely, independently, without intervention? Yes, staff to report any concern with unsafe smoking habits or smoking in her room to nursing staff. General Safety: resident smokes -resident knows where designated smoking area is, how to extinguish tobacco products, not to smoke in building. Verbalized understanding, demonstrates safe smoking habits. R7's Service Plan Agreement dated April 17, 2024, indicated R7 received services including behavior management, deep room clean, linen change, medication administration, vital sign monitoring and safety checks three times daily. On April 30, 2024, at 12:08 p.m., ULP-H stated he does not take medications to R7's room and does not have reason to go to her room. On April 30, 2024, at 12:11 p.m., housekeeper (HK)-H stated she cleans R7's room weekly	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 830	Continued From page 17 adding R7 likes to do much of the cleaning herself. HK-H stated she had reported R7 kept smoking supplies (cigarettes and lighters) in her room. On April 30, 2024, at 1:23 p.m., registered nurse (RN)-B stated absolutely we have resident's smoking in there rooms, it is so hard with this demographics. RN-B added "I" (licensee) have to be harder on them (smoking residents.) The Minnesota Department of Health's (MDH) Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics... MDH enforces the MCIAA and can delegate enforcement to community health boards. Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensee's Resident Handbook dated August 30, 2022, noted periodic inspections of the apartments by staff may be necessary to ensure the health, safety, and general maintenance of the building. In addition, all [licensee names] facilities are smoke-free. This policy prohibits smoking in any area inside the facility-including your apartment and any common area within the	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
0 830	Continued From page 18 facility by any resident and its visitor (s). There are designated smoking areas at each facility outside. The licensee's Smoking/Vaping policy dated July 31, 2022, noted smoking/vaping shall be prohibited in all enclosed areas of any [licensee name] facility. This includes, but is not limited to, all common areas, facility rooms, hallways, stairs, lobby areas, dining areas, elevator, restrooms, and any other enclosed area. Failure to follow this policy will result in terminating your lease. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor review on May 1, 2024, however noncompliance remains at a scope and level of three, isolated (G).	0 830		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment for one of three residents (R2) who received medication	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 19 management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses include asthma/chronic obstructive pulmonary disease overlap syndrome (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder, such as depression or mania), diabetes, and chronic kidney disease (mild to moderate damage, kidneys are less able to filter waste and fluid out of blood). R2's Service Plan dated April 18, 2024, indicated R2 received the following services: -medication administration six times per day: HHA/RA (home health aid/resident assistant/unlicensed personnel/ULP) -medication administration every ten days: nurse -medication administration five days a week: nurse. On April 30, 2024, at 7:29 a.m., the surveyor observed ULP-G prepare R2's morning medication. R2 asked for his "breathing apparatus." ULP-G removed a plastic bag from the medication cart. ULP-G removed a spacer (used to improve the delivery of medication from	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 20 an inhaler) from the plastic bag and placed it on the table close to where R2 was seated. ULP-G set the plastic bag on the table near R2. On April 30, 2024, at 7:36 a.m., the surveyor observed R2 self-administer seven units of Levemir (long-acting) insulin in his right upper arm using correct technique. R2 placed the spacer onto the Advair inhaler R2 removed from the plastic bag, shook the inhaler, and inhaled the medication. R2 opened a small, foiled container and placed the medication into the Spiriva machine and crushed the medication and inhaled the medication using correct technique. R2's medication administration summary (record/MAR) dated April 1, 2024, through April 29, 2024, included: -Advair Hfa (asthma/COPD) 115 micrograms (mcg)-21 mcg Aer daily, inhale two puffs into the lungs two times a day. Shake well. Rinse mouth after use. Use spacer -Spiriva (used to prevent narrowing of airways/asthma 18 mcg powder for inhalation daily. Inhale one capsule into the lungs one time a day. Take capsule from foil blister right before use: place in chamber of handilhaler (breath-activated, egg-shaped inhaler used for COPD medications) -Levemir FlexTouch, client to "self" inject seven units subcutaneously (under skin) three times daily with meals. Staff to ensure correct dial up of pen; remind to hold needle in place for five to ten seconds before removing. R2's prescriber order dated March 6, 2024, included the above medication. R2's Individualized Medication Management Plan dated March 20, 2024, noted:	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 21 -staff will administer all medications per MD (medical doctor) orders -needs help with medication other than oral: nebular, inhaler -staff will assist with administration of subcutaneous medication as ordered; staff will offer privacy while resident self-injects insulin -staff will monitor client self-inject insulin and administer oral medications per providers orders and document accordingly in client's (resident's) MAR. On April 30, 2024, at 3:00 p.m., RN-B stated R2's medication assessment required updating to allow R2 to self-administer inhaler medications. RN-B confirmed R2's medication assessment had not been updated as required. The licensee's Medication & Treatment-Administration & Delegation policy dated July 12, 2023, noted an RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services would be provided and how those services would be provided. The licensee's Medication Management-Assessment, Monitoring & Reassessment policy dated July 12, 2023, noted the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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 22	01760		
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: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (R2) who received medication management services. 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: R2's diagnoses include asthma/chronic	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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 23 obstructive pulmonary disease overlap syndrome (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder, such as depression or mania), diabetes, and chronic kidney disease (mild to moderate damage, kidneys are less able to filter waste and fluid out of blood). R2's Service Plan dated April 18, 2024, indicated R2 received the following services: -medication administration six times per daily: HHA/RA (home health aid/resident assistant/unlicensed personnel/ULP) -medication administration every ten days: nurse -medication administration five days a week: nurse. R2's medication administration record (MAR) dated April 1, 2024, through April 29, 2024, included: -aspirin 81 milligrams (mg) chewable tablet. Chew and swallow one tablet by mouth once daily for heart health. R2's prescriber order dated March 6, 2024, included: -aspirin 81 milligrams (mg) chewable tablet. Chew and swallow one tablet by mouth once daily for heart health. On April 30, 2024, at 7:29 a.m., the surveyor observed ULP-G prepare R2's morning medication. ULP-G reviewed R2's MAR and placed amlodipine (lowers blood pressure) 2.5 mg, aspirin 81 mg , benztropine (anxiety/ panic) 2 mg, Buspar (anxiety)10 mg, calcium 600 mg & vitamin D3 (supplement) 10 micrograms (mcg),	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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 24 duloxetine (antidepressant) 30 mg and 60 mg, duloxetine 30, metoprolol (heart) 25 mg, oxybutynin (bladder relaxant) 5 mg, risperidone (behaviors) 4 mg, Tab-a Vite (supplement), vitamin C (supplement) 500 mg into a medication cup and administered the medication to R2. The surveyor did not observe R2 chew aspirin 81 mg. On April 30, 2024, at 8:40 a.m., R2's MAR was reviewed with ULP-G. ULP-G stated R2 will not chew it (aspirin) for me. "I (ULP-G) knew he won't do it for me, should I have asked him, should I ask every time?" ULP-G confirmed the directions on R2's MAR were not followed as required. On April 30, 2024, at 1:11 p.m., registered nurse (RN)-B stated directions on the MAR should be followed. RN-B confirmed R2's aspirin was not administered as ordered. The licensee's Medication & Treatment Orders policy dated July 12, 2023, noted the ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to an RN. In addition, the licensed nurse would monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. The licensee's Medication & Treatment-Administration & Delegation policy dated July 12, 2023, noted when administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the license would ensure that the registered nurse had: -instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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 25 procedures. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one medication cart. In addition, the licensee failed to ensure medication were stored under double lock (narcotic) for one of four residents (R6). Further, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of two residents (R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01880	Continued From page 26 The findings include: MEDICATION CART On April 30, 2024, at approximately 10:00 a.m., the surveyor observed the medication cart in the open medication room unlocked. The interior door/nurse's office was also open and vacant. The medication room was off the main entrance of the facility. The surveyor observed two residents in the adjoining open dining area and two unlicensed personnel (ULP) both with their backs to the entrance area and medication room. On April 30, 2024, at 10:07 a.m., registered nurse (RN)-B stated the medication cart was to be locked at all times when not in use. On April 30, 2024, at 10:08 a.m., ULP-G stated "they" (ULP-H and ULP-G) forgot to lock the medication cart. ULP-G said ULP-H was "out talking" and he (ULP-G) went to get water (from the kitchen.) On April 30, 2024, at 10:10 a.m., ULP-H stated he "thought" the medication cart was locked. ULP-H confirmed the medication cart was not secure as required. On April 30, 2024, at 1:14 p.m.., RN-B stated ULPs are taught anytime they turn their back on the medication cart the cart should be locked. UNSECURED NARCOTIC R6's diagnosis include generalized anxiety disorder, major depressive disorder, and post-traumatic stress disorder (PTSD/mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashbacks and avoidance of	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01880	Continued From page 27 similar situations.). R6's Service Plan dated April 17, 2024, indicated R6 received the following services: -medication administration five times daily. R6's prescriber's order dated March 28, 2024, included: -Zubsolv (to treat opioid use disorder, scheduled III prescription drug/narcotic classified by the federal government) 11.4- 2.9 milligrams (mg) under tongue twice daily, dissolve one table under the tongue twice daily for addiction. On April 30, 2024, at 7:00 a.m., the surveyor observed ULP-H and ULP-I performing the shift change narcotic count. ULP-H read Zubsolv, R6. ULP-I did not find R6's Zubsolv in the double locked drawer. ULP-I then turned to a single locked wall cabinet, opened the paddle lock and pulled out R6's Zubsolv from an open shelf area. On April 30, 2024, at 7:05 a.m., ULP-I stated "I probably did (put R6's narcotic in the single locked cabinet)." ULP-I added, "at least it was locked up." ULP-I said she had recently administered R6's Zubsolv. ULP-I confirmed R6's narcotic was not double locked as required. On April 30, 2024, at 1:20 p.m., RN-B stated R6's should have been double locked. RN-B confirmed R6's narcotic was not double locked as required. UNSECURED MEDICATION IN RESIDENT ROOM R8's diagnoses include bipolar disorder (periods of depression and manic behavior), obesity, and pre-diabetes. R8's Service Plan dated August 25, 2023,	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01880	Continued From page 28 indicated R8 received the following service: -medication administration two times daily. On April 30, 2024, at 12:11 p.m., the surveyor observed housekeeper (HK)-H cleaning R8's room. In addition, the surveyor observed several medication bottles in R8's room unsecured. R8's Assessment dated February 2, 2024, noted: -staff trained by the RN would administer all medications per MD (medical doctor) orders -all medication is locked behind key-access lick and locked safe: designated staff only have access to all medication, medication is not to be left unattended by administering staff. On April 30, 2024, 12:38 p.m., medication assessment was reviewed with RN-B. RN-B confirmed R8's medication assessment indicated R9's medication should be secured. On April 30, 2024, at 1:23 p.m., the surveyor and RN-B observed and confirmed the following in R8's room: -one empty ibuprofen (mild pain) bottle -one opened ibuprofen bottle -one unopened bottle of calcium, magnesium and zinc (supplements) vitamins -one opened instant oral pain relief in a dropper bottle -one opened ginkgo (supplement) bottle. RN-B stated with the "demographics (population)" served it was difficult to monitor medication in rooms, as "they" (residents) go to "Walmart." RN-B confirmed not all of R9's medications were secured as required. The licensee's Medication Storage policy dated July 12, 2023, noted medication would be stored	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01880	Continued From page 29 consistent with each resident's medication management plan and service plan. Medications managed by Hillcrest/Chestnut Grove would be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. In addition, scheduled II drugs would be stored under a double lock system and stored separately from other medications. Further, medications managed inside a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be in locked drawer, cabinet, etc. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01950	Continued From page 30 ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R2) receiving treatments. 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: R2's diagnoses include asthma/chronic obstructive pulmonary disease overlap syndrome (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder, such as depression or mania), diabetes, and chronic kidney disease (mild to moderate damage, kidneys are less able to filter waste and fluid out of blood) R2's Service Plan dated April 18, 2024, indicated R2 received the following services:	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01950	Continued From page 31 -intake of fluids, three times per day, daily -record weight, daily. On April 30, 2024, at 7:29 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R2's morning medication and administer with unmeasured water. On April 30, 2024, at 7:46 a.m., the surveyor observed ULP-G ask R2 to get on the scale. ULP-G obtained a weight of 216.6 pounds for R2. R2's record included: active date January 25, 2023 Record-weight- AM (morning), daily -instructions: record resident weight. R2's record included: active date December 11, 2022 Intake of Fluids 8:30 a.m., daily -instructions: document fluid intake: fluids restricted, only allowed one eight-ounce glass of liquid with meals (240 cc/cubic centimeter-measurement) and four ounces with each medication administration (120 cc). Leaves an additional 800 milliliters (ml) through the day. Remind him of his 2000 ml fluid restrictions when needed (PRN). R2's prescriber's orders dated March 6, 2024, included: -record: intake of fluids daily, three times -record: weight, daily. On April 29, 2024, at 1:48 p.m., R2's record was reviewed with RN-B. RN-B stated R2's record did not include instructions for R2's weight, what and when ULPs should report to nursing. RN-B added R2's weight was being monitored weekly and said she was not sure why R2's weight was being	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39299	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST TERRACE	1507 EAST 41ST STREET HIBBING, MN 55746

(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
01950	Continued From page 32 done daily. On April 29, 2024, at 3:07 p.m., the surveyor and RN-B reviewed R2's intake of fluids entry. RN-B confirmed R2's record did not include specific information as required. RN-B added R2 was independent with his fluid intake. The licensee's Medication & Treatment-Administration & Delegation policy dated July 12, 2023, noted when a treatment/therapy was delegated or assigned to unlicensed personnel, the licensee would ensure the register nurse had: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records -communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

Type: Full
Date: *04/29/24*
Time: 10:30:00
Report: 7983241089

Food and Beverage Establishment Inspection Report

Location:
Hillcrest Terrace
1507 East 41st Street
Hibbing, MN55746
St. Louis County, 69

Establishment Info:
ID #: 0041671
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.110 ***** Priority 2 *****

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

THE WASH WATER TEMPERATURE OF THE WAREWASHING MACHINE WAS 95 F.

Comply By: 05/06/24

Surface and Equipment Sanitizers

Chlorine: = 100 at 95 Degrees Fahrenheit
Location: Wash and rinse temperature of the warewashing machine.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Maximum double-door upright freezer in the storage area in the kitchen was frozen solid.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Cooler Depot double-door upright freezer in the kitchen was frozen solid.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Whirlpool single-door upright freezer in the dry storage room near the office was frozen solid.
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Sliced Swiss cheese in the Arctic Air single-door upright refrigerator in the kitchen.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Macaroni & cheese in the Arctic Air double-door upright refrigerator in the kitchen.
Violation Issued: No

Process/Item: Milk Dispenser
Temperature: 34 Degrees Fahrenheit - Location: Milk.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: Beef stew on the stovetop.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 95 Degrees Fahrenheit - Location: Wash and rinse water of the warewashing machine.
Violation Issued: Yes

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

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Provided an illness reporting fact sheet, an employee illness decision guide, an employee illness log, a vomit cleanup poster, a TCS food fact sheet, a temperature requirement fact sheet, and a cooling fact sheet.

3) Observed thawing under refrigeration and date marking.

==========

Type: Full
Date: *04/29/24*
Time: 10:30:00
Report: 7983241089
Hillcrest Terrace

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 7983241089 of 04/29/24.

Certified Food Protection Manager: Holli Johnson

Certification Number: FM62527 Expires: 06/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Dorothy White
Person in Charge

Signed: 7983
Gary Collyard
Public Health Sanitarian III
218-940-9306
gary.collyard@state.mn.us