Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISONAL LICENSE - LICENSE GRANTED

Electronic Delivery

September 18, 2024

Licensee
High Drive Customized Assisted Living LLC
13813 High Drive
Burnsville, MN 55337

RE: Initial License Number 412603
Health Facility Identification Number (HFID) 39715
Project Number(s) SL39715015

Dear Licensee:

On September 3, 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 September 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 September 9, 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.
Executive Regional Operations Manager

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
July 16, 2024

Licensee
High Drive Customized Assisted Living LLC
13813 High Drive
Burnsville, MN 55337

RE: Provisional Conditional License Number 412603
Health Facility Identification Number (HFID) 39715
Project Number(s) SL39715015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 14, 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.

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.**

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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.

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

CONDITIONAL LICENSE ISSUED:
MDH will issue High Drive Customized Assisted Living LLC a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 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 High Drive Customized Assisted Living LLC is in substantial compliance.

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

a. **No new admissions:** High Drive Customized Assisted Living LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. High Drive Customized Assisted Living LLC must provide the Department:

    i. A list of the names and birthdates of any individuals High Drive Customized Assisted Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

b. Health Facility Construction Permit: High Drive Customized Assisted Living LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, High Drive Customized Assisted Living LLC, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

c. General Contractor: High Drive Customized Assisted Living LLC must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:

i. Name
ii. License Number
iii. Contact Information

d. Egress Window Requirements: High Drive Customized Assisted Living LLC will replace at least one window in occupied resident sleeping rooms #1, #2, #3, and #4 meeting the minimum size requirements.

i. Must have a minimum openable width of no less than 20 inches
ii. Must have a minimum openable height of no less than 20 inches
iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if High Drive Customized Assisted Living LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines High Drive Customized Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to High Drive Customized Assisted Living LLC. If MDH determines High Drive Customized Assisted Living LLC 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 Jodi Johnson directly at: 507-344-2730.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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: SL39715015-0 On June 10, 2024, through June 12, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the provider's provisional Assisted Living license. An immediate correction order was identified on June 12, 2024, issued for SL39715015-0, tag identification 0820. On July 1, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a licensee'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: The licensee held an Assisted Living license and was licensed for a capacity of five residents with a current census of four residents. On June 10, 2024, at 10:50 a.m. upon entrance to the facility, the surveyor observed a document labeled as the staffing plan posted on the bulletin board in the dining room area. The schedule included the days of the week (Sunday through Saturday) and the staff names for the shifts (12-hour days/nights). On June 10, 2024, at 12:00 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the posting was the staff schedule for the current week and was currently being edited with unlicensed personnel needing to leave the country on an emergent basis. LALD/CNS-A indicated he had not completed a separate document to indicate the actual staffing plan that he signed or dated to indicate his review since the facility opened on October 1, 2023. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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 June 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630	Continued From page 4	0 630		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, 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 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: R1 R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided	0 630		

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0 630	Continued From page 5 paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1 was admitted to the Assisted Living Facility on October 1, 2023, to receive direct care services. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's gastrostomy feeding tube. ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. R1's IAPP found within his admission assessment dated October 1, 2023, included a section labeled "Susceptible to abuse by others in home or community environment" with a yes/no option which was blank. The licensee failed to indicate R1's susceptibility to abuse from others including other vulnerable adults and lacked interventions to minimize his risk of abuse from others. On June 11, 2024, at 9:30 a.m. licensed assisted	0 630		

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0 630	Continued From page 6 living director/clinical nurse supervisor (LALD/CNS)-A indicated the IAPP was incomplete, R1 was a vulnerable adult and was susceptible to abuse by others. R3 R3's diagnoses included essential hypertension. R3 was admitted to the Assisted Living Facility on October 1, 2023, to receive direct care services. R3's Service Plan dated October 1, 2023, indicated he received the services of medication administration, assistance with dressing, bathing, toileting, shaving, compression stockings, meal set up and housekeeping. On June 11, 2024, at 7:26 a.m. ULP-C was observed to administer five oral medications to R3 with breakfast. R3's IAPP found within his admission assessment dated September 29, 2023, included as section labeled "Susceptible to abuse by others in home or community environment" with a yes/no option. The "Yes" option was checked; however, the licensee failed to indicate interventions to minimize his risk of abuse from others. On June 11, 2024, at 9:40 a.m. LALD/CNS-A indicated the interventions were not included and would review and update the IAPP. The licensee's Vulnerable Adult policy dated February 7, 2023, indicated the assisted living employee has responsibility for the following: -an assessment of vulnerability status of each resident upon admission. Susceptibility to abuse includes self-abuse and neglect and risk of abuse	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 630	Continued From page 7 by other individuals, including other vulnerable adults, in the following areas: physical, verbal (emotional/psychosocial), sexual, financial exploitation, and self-abuse. Furthermore, the plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting 911 emergency number as required. This had the potential to affect all residents, staff, and visitors.	0 640		

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0 640	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 10, 2024, at 12:05 p.m. during a facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor noted no 911 emergency number posting in the facility common areas or by facility supplied telephones as required. LALD/CNS-A indicated he thought it was posted somewhere, looked but could not find it. He stated he would create one for the bulletin board and one for above the house phone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	0 690		

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0 690	Continued From page 9 Based on interview and record review, the licensee failed to ensure entries in one of one resident's record (R1) were authenticated by the title of the person making the entry. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1's record included the licensee's "charting sheet" dated May 1, 2024, through May 31, 2024, which included multiple daily tasks and several staff initials; however, the record lacked staff signatures with credentials/titles. R1's record included the licensee's "diabetic flow sheet" dated October 3, 2023, through May 27, 2024, which included weekly blood sugar results, dates, and staff initials; however, the document lacked staff signatures with credentials/titles. On June 11, 2024, at 10:00 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the task records and blood sugar tracking record used by the licensee did not include a signature page or credentials to match the staff initials found on the documents. LALD/CNS-A stated all resident charting sheets and diabetic flow sheets would lack this information. The licensee's Clinical Records policy dated	0 690		

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	39715	A. BUILDING: _____ B. WING _____	06/12/2024

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0 690	Continued From page 10 February 7, 2023, indicated all entries into the clinical record will be legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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0 730	Continued From page 11 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of content in the resident's record as required for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's Service Plan dated October 2, 2023,	0 730		

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0 730	Continued From page 12 indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's gastrostomy (G-Tube) feeding tube. ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. R1's record included the licensee's "Charting Sheet" which included various tasks for the unlicensed staff to complete, but lacked the description of which tasks were specifically related to R1 and when the tasks were to be completed (each shift, daily, weekly, or as needed). The Charting sheet included columns labeled "AM, PM, and LN" with each assigned day, and included staff initials with some tasks, with other tasks lacked any staff initials. Additionally, some tasks were unclear as to what staff were documenting. The tasks included: -dressing; no frequency indicated -stockings/TED (compression stockings)- used for right protective boot; however, did not indicate this was what was being documented and what frequency was assigned; -bath- no frequency indicated; -shampoo- no frequency indicated;	0 730		

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0 730	Continued From page 13 -oral care; no frequency indicated -shaving-no documentation, no frequency indicated; -dentures-no documentation; no frequency indicated; -foot care-no frequency indicated; -skin care- no frequency indicated; -toileting-incontinent pads- used to document R1's condom catheter bag emptying or catheter change; however, the task did not indicate this or which task was completed; -meal prep (G-tube)-used to document R1's G-Tube feeding and water infusion via feeding pump; however, the task did not indicate what actual task was completed (feeding change/water change/feeding started); -transfer assist-lacked an indication how often assigned and how to transfer (R1 transfers with Hoyer lift); -medication assistance/MAR (medication administration record); no frequency -vital signs-no documentation, no frequency; -blood glucose (blood sugar check)-no documentation or indication to document results on an alternate record (R1's record included a separate document for blood sugar check results); -behavior/orientation-no direction/frequency; -treatments-one line included both trach (tracheostomy) suctioning and vest therapy (CPT), included staff initials; however, no indication to what task was completed and what frequency was assigned. On June 11, 2024, at 10:10 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the licensee's Charting Sheets were vague in what tasks were being completed and how often they were assigned per the Service Plans. He indicated the staff know	0 730		

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0 730	Continued From page 14 which tasks were to be completed and when they were to be completed; however, the Charting Sheets did not indicate the above listed details nor the frequency of what was to be completed. LALD/CNS-A indicated the Charting Sheets for all residents were similar. The licensee's Resident Record policy dated February 7, 2023, indicated contents of the resident record would include documentation that services have been provided as identified in the service plan. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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 maintain the portable fire extinguishers.	0 790		

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0 790	Continued From page 15 This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on June 12, 2024, at approximately 11:30 a.m., the surveyor toured the facility with the licensed assisted living director (LALD/CNS)-A. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification on the portable fire extinguishers. The fire extinguishers had a certification tag indicating they were last inspected in August 2022. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview, survey staff explained to LALD/CNS-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD/CNS-A	0 790		

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0 790	Continued From page 16 verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 820 SS=I	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 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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	0 820	This immediate correction order identified on June 12, 2024, has had the immediacy lifted as of July 1, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 17 portion or all of the residents). Findings include: On a facility tour on June 12, 2024, at 11:30 AM with (LALD/CNS)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms #1, #2, #3 and #4. Occupied Resident Rooms Resident sleeping room #1, #2 and #3 emergency escape and rescue clear window opening measurements are 18 inches wide, 36 inches in height and 44 inches off the floor. Resident sleeping room #4 emergency escape and rescue clear window opening measurements are 18 inches wide, 48 inches in height and 32 inches off the floor. All bedrooms are on the upper level of the home. The windows do not meet the 20 inches minimum requirements for width. The windows were measured with the LALD/CNS-A, and survey staff present. It was explained to LALD/CNS-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by LALD/CNS-A accompanying on the tour. The surveyor explained that an immediate correction	0 820		

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0 820	Continued From page 18 order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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01060	Continued From page 19 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted to the Assisted Living Facility on October 1, 2023, to receive direct care services. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning,	01060		

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01060	Continued From page 20 blood sugar checks (weekly), and housekeeping. R1's record included an after-visit summary (AVS) dated March 18, 2024, which indicated R1 was hospitalized from February 26, 2024, to March 18, 2024, for pneumonia. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On June 10, 2024, at 4:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he understood the emergency relocation form was used for emergency evacuations from the facility and didn't realize the form and notification was required for any hospitalizations or extended hospitalizations.	01060		

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01060	Continued From page 21 The licensee's Discharge and Transfer of Residents policy dated February 7, 2023, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: - the resident - the resident's legal representative - the resident's designated representative - if the resident receives home and community-based services, the resident's case manager - if the resident has been relocated and not returned to Garden View Home Health within four (4) days, the Office of Ombudsman for Long-Term Care - notice of the right to appeal the decision under 144G.54 Additionally, the written notice shall include the following: -the reason for the relocation - name and contact information for the location to which the resident has been located and any new service provider - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities - if known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal. No further information was provided.	01060		

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01060	Continued From page 22 TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 23 licensee failed to ensure the service plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the Assisted Living Facility on October 1, 2023, to receive direct care services. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused	01650		

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	39715	A. BUILDING: _____ B. WING _____	06/12/2024

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HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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01650	Continued From page 24 a continuous flow of either feeding or water through R1's gastrostomy feeding tube. Additionally, the surveyor noted a mechanical device on R1's bedside table. ULP-B stated the device was a chest physiotherapy (CPT) device with a vest (worn over/around R1's chest/ribs to provide a mechanical means to loosen secretions in the lungs). ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. ULP-B stated the staff were tasked to ensure R1's oxygen concentrator was always at four liters/minute, was humidified with the humidification machine and provided direct flow to R1' tracheostomy via a tracheostomy flow-by mask; she further stated the staff used the CPT vest twice daily. R1's record included an undated, document labeled "Special instruction for Medication and Treatment" which included the following: -Connecting tubes change twice monthly; -Tracheostomy tube change monthly by nurse; -Airway clearance therapy-twice daily AM and PM suction after therapy; -Oxygen-concentration at 4 liters while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater than 92% turn oxygen off and turn on when in bed; -Humidifier to trach should be between three and four, make sure the pump is on, pump is in the bathroom. Hand wash filters in oxygen concentration and humidifier pump monthly. R1's record included the licensee's "Charting Sheet" which included various tasks for the unlicensed staff to complete. The Charting Sheets dated May 1, 2024, through May 31, 2024, included a line where both tasks of tracheal	01650		

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01650	Continued From page 25 suctioning and CPT vest therapy were to be documented. R1's Service Plan lacked the services of: - oxygen; -continuous oximetry (a unit that measures the body's oxygen concentration via a sticky finger probe); - tracheostomy humidifier; and - CPT vest On June 11, 2024, at 10:35 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the above listed treatments were not included in R1's Service Plan and would add them. The licensee's Service Plan policy dated February 7, 2023, indicated the service plan would include: - A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; - The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; and - The identification of the staff or categories of staff who will provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730		

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01730	Continued From page 26 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of one resident (R1) receiving medication administration 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 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: R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration. On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water	01730		

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01730	Continued From page 28 through R1's gastrostomy feeding tube(G-Tube). ULP-B indicated R1 received all his medications through his G-Tube. R1's medication administration record (MAR) dated May 2024, indicated he received one medication for acid reflux, one for muscle spasms, five to manage bowel, one for depression, one for dry eyes, one for cholesterol, one for anxiety, one for agitation, one for mild pain, one nebulizer for breathing, and four supplements. R1's Service plan dated October 2, 2023, included R1's Medication Plan. The Medication Plan lacked the required content to include: --identification of the medication management tasks that may be delegated to unlicensed personnel. On June 11, 2024, at 10:45 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the Medication Plan template used by the licensee did not include the required content for the licensee to identify the medication management tasks that may be delegated to unlicensed personnel. Furthermore, LALD/CNS-A indicated the same Medication Plan template was used for the three other residents who received medication services. The licensee's Service Plan for Medication Management policy dated February 7, 2023, indicated the written Medication Management Plan included a description of medication management tasks to be delegated to unlicensed personnel. No further information was provided.	01730		

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01730	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide instructions for as needed (PRN) medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1	01750		

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01750	Continued From page 30 R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube (G-tube). R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration. R1's medication orders dated October 20, 2023, and March 18, 2024, included one medication for acid reflux, one for muscle spasms, five to manage bowel/constipation, one for depression, one for dry eyes, one for cholesterol, one for anxiety, one for agitation, one for mild pain, one nebulizer for breathing, one oral rinse, one dental paste and four supplements. On June 10, 2024, at 12:24 p.m. ULP-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy cuff (a cup like device) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's G-Tube. ULP-B indicated R1 received all oral medications through his G-Tube. R1's medication administration record (MAR) dated May 2024, indicated as needed (PRN) medications including: -acetaminophen 500 milligrams (mg), give two tablets via G-tube two times daily as needed (for pain); -Ibuprofen 600 mg, give one tablet via G-tube every eight hours as needed (for pain); -polyethylene glycol 3350, give 17 grams (gm) with liquid twice daily for constipation; and	01750		

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01750	Continued From page 31 -bisacodyl suppository, 10 mg, insert one suppository rectally one time daily as needed (for constipation). The licensee failed to indicate/provide instruction for which PRN medications should be used first and second for pain or constipation. On June 11, 2024, at 10:15 a.m. LALD/CNS-A indicated R1's MAR was unclear as to what PRN medications should be used first to address pain/fever or constipation. The licensee's Medication Administration policy dated February 7, 2023, indicated the registered nurse (RN) will prepare written instructions for the home health aide (ULP) in the proper methods to administer medications with respect to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	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	01760		

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01760	Continued From page 32 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 all medications were documented as administered for one of one resident (R1). In addition, the licensee failed to include staff titles with their signatures on the medication administration record (MAR) for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: DOCUMENTATION OF MEDICATIONS ADMINISTERED R1 R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration.	01760		

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01760	Continued From page 33 On June 10, 2024, at 1:50 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-B were observed to provide an incontinent brief change for R1 following his bowel movement. The surveyor noted a box holding individually dosed eye drops and individually packaged nebulizer solution on the bedside table next to R1. Additionally, a bottle chlorohexidine (prescription oral rinse), a tube of prescription toothpaste, and a bottle of antifungal powder was noted on another table across the room. LALD/CNS-A stated the above noted medications were kept in R1's room for ease of use during cares. R1's medication orders dated March 18, 2024, included: -chlorhexidine 0.12 % solution, 15 milliliters (ml) oral rinse and spit, once daily (oral protection); -Denta 5000 plus 1.1% cream (toothpaste), brush with a small amount twice daily (after breakfast and before bed), instead of toothpaste, then spit; and -miconazole 2% external powder, apply topically as needed for itching or other R1's MAR dated May 2024, included one medication for acid reflux, one for muscle spasms, five to manage bowel/constipation, one for depression, one for dry eyes, one for cholesterol, one for anxiety, one for agitation, two for mild pain, one nebulizer for breathing, and four supplements. The licensee failed to complete documentation for administration of R1's chlorhexidine oral rinse, Denta 5000 plus prescription toothpaste, and antifungal powder.	01760		

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01760	Continued From page 34 On June 12, 2024, at 10:00 a.m. LALD/CNS-A indicated he didn't realize the above listed medications were missing from R1's MAR. The licensee's Medication Documentation policy dated February 7, 2023, indicated each medication administered by [licensee's name] would be documented in the resident's clinical record. MEDICATION ADMINISTRATION RECORD SIGNATURES/STAFF TITLE R1 R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration. On June 10, 2024, at 12:45 p.m. ULP-B was observed to provide tracheostomy suctioning for R1. ULP-B stated R1 received all feedings/water infusions and oral medications through his gastrostomy feeding tube (G-tube). R1's MAR dated May 2024, included one medication for acid reflux, one for muscle spasms, five to manage bowel/constipation, one for depression, one for dry eyes, one for cholesterol, one for anxiety, one for agitation, two for mild pain, one nebulizer for breathing, and four supplements. R2 R2's Service Plan dated October 3, 2023, indicated she received the services of medication administration.	01760		

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01760	Continued From page 35 On June 11, 2024, at 7:25 a.m. ULP-C was observed to administer seven oral medications to R2. R2's MAR dated May 2024, indicated she received one medication for blood thinning, one topical antibiotic, one for heart rate control, one for dementia management, one eye drop for glaucoma, one for blood pressure, one antifungal for skin, and three supplements. R3 R3's Service Plan dated October 1, 2023, indicated he received the services of medication administration. On June 11, 2024, at 7:28 a.m. ULP-C was observed to administer five oral medications and observed self-administration of nasal spray by R3. R3's MAR dated May 2024, indicated he received one medication for acid reflux, three for blood pressure control, two supplements, two for allergies (one oral, one nasal spray), one for mild pain. R1, R2, and R3's MARs dated May 2024, included staff initials and staff signatures (some were only first name); and lacked staff titles. The licensee's Medication Documentation policy dated February 7, 2023, indicated documentation for medication administration included signature and title of staff administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 36 days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's medication refrigerator was maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations for two of two residents (R1, R2). Additionally, the licensee failed to ensure all medications were securely stored for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 June 10, 2024, at 10:45 a.m. during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated resident medications were securely stored in a medication cabinet and medications that required refrigeration were stored in a small, locked refrigerator in the kitchen.	01880		

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01880	Continued From page 37 MEDICATION REFRIGERATOR TEMPERATURE On June 10, 2024, at 4:15 p.m. the surveyor and LALD/CNS-A reviewed the contents of the licensee's small, locked refrigerator found in the kitchen/dining room area. The refrigerator lacked a thermometer to for staff to monitor the temperature for the medications stored within. LALD/CNS-A stated no temperature monitoring had been completed as he was not aware of the requirement. The medications stored within the refrigerator included: -R1's baclofen (for muscle spasms), 10 milligrams/milliliter (mg/ml)-one 180 ml bottle and one bottle with less than 10 ml; -R1's magnesium sulfate (for bowel management), 500 mg/ml-one bottle with less than 10 ml; -R1's pantoprazole (for acid reflux), 2 mg/ml two unopened bottles each with 1200 ml and one opened bottle with approximately 260 ml; -R1's bisacodyl suppositories (for bowel management)-21 suppositories; -R2's latanoprost eye drops for glaucoma seven unopened bottles. R1's Baclofen liquid (SyriMed manufacturer's leaflet) dated September 2021, indicated storage below 25 degrees Celsius. R1's magnesium sulfate 500 mg/ml liquid was compounded by the pharmacy; included a refrigerate sticker; however no further storage instructions were included. R1's pantoprazole bottle indicated it was	01880		

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01880	Continued From page 38 compounded by the pharmacy; included a refrigerate sticker; however, no further instructions for storage were included. R1's bisacodyl suppository-Mayo Clinic bisacodyl storage information dated February 1, 2024, indicated bisacodyl suppositories were to be stored at room temperature and not frozen. R2's latanoprost eye drops box indicated storage temperature range was 36-46 degrees Fahrenheit (F). MEDICATION STORAGE R1 R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration. R1's Medication Management plan as part of the Service Plan dated October 2, 2023, lacked specific storage considerations/locations for his medications. R1's record included an undated, document labeled as Special Instructions for Medications and Treatments which indicated a section for where medication was stored that read, "Pills and supplements: In [R1's] Medication cabinet, liquid medication: Some in medication refrigerator, some in [R1's] medication cabinet. Eye drops, ointments, and Albuterol for nebulizer on bedside table."	01880		

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01880	Continued From page 39 On June 10, 2024, at 1:50 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel (ULP)-B were observed to provide an incontinent brief change for R1 following his bowel movement. The surveyor noted a box holding individually dosed eye drops and individually packaged nebulizer solution vial on the bedside table next to R1. Additionally, a bottle chlorohexidine (prescription oral rinse), a tube of prescription toothpaste, and a bottle of antifungal powder was noted out in the open on another table across the room. LALD/CNS-A stated the above noted medications were kept in R1's room for ease of use during cares. The licensee failed to securely store the above noted medications within R1's bedroom. On June 11, 2024, at 10:25 a.m. LALD/CNS-A indicated the medications listed above found in R1's room were in the open and could be accessed by other residents in the facility. The licensee's Storage/Control of Medications policy dated February 7, 2023, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-45 degrees. When [licensee's name] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided.	01880		

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01880	Continued From page 40 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	01940		

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01940	Continued From page 41 Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include consistent information with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. R1's Service Plan lacked the services of oxygen, tracheostomy humidifier, continuous oximetry (a unit that measures the body's oxygen concentration via a sticky finger probe), and chest physiotherapy (CPT) vest device (worn over/around R1's chest/ribs to provide a mechanical means to loosen secretions in the lungs).	01940		

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01940	Continued From page 42 On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's gastrostomy feeding tube. R1 was observed to have a pulse oximeter unit providing continual oxygen concentration measurements as attached to a finger. Additionally, the surveyor noted a mechanical device on R1's bedside table. ULP-B stated the device was a CPT vest worn twice daily. ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. ULP-B stated the staff were tasked to ensure R1's oxygen concentrator was always at four liters/minute, was humidified with the humidification machine and provided direct flow to R1' tracheostomy via a tracheostomy flow-by mask. R1's Treatment plan found as part of R1's Service Plan dated October 2, 2023, indicated the treatment of trach (tracheostomy) suctioning daily two to three times and as needed, and vest therapy (CPT vest) once daily. R1's record included an undated, document labeled Special Instructions for Medications and Treatments which included the following Treatment Plan information: -Nebulizer with Albuterol solution when necessary; -Suction (tracheostomy): 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and every two hours when needed for increased secretions;	01940		

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01940	Continued From page 43 -Tracheostomy tube change monthly by nurse; -connecting tubes change twice monthly; -Airway clearance therapy (CPT vest) twice daily AM and PM, suction after therapy; -oxygen concentration at four liters/minute while in bed to keep oxygen saturation 90% or greater. -Humidifier to trach should be between three and four, make sure the pump is on, pump is in the bathroom. Hand wash filters in oxygen concentrator and humidifier pump monthly. R1's record included a document labeled Diabetic Flow Sheet with blood sugar readings from October 3, 2023, through May 27, 2024. The instructions indicated check blood glucose (sugar) every Tuesday morning before tube feeding start. R1's Service Plan included the treatment of weekly blood sugar checks by ULP; however, the licensee failed to include blood sugar checks in the Treatment Plan and failed to provide instructions/blood sugar parameters for when the ULP would notify a nurse. R1's Treatment Plan indicated CPT vest used daily by the ULP; however, the Special Instructions for Medications and Treatments indicated twice daily (a.m. and p.m.) The information did not match. Furthermore, the instructions lacked the duration of CPT vest use. R1's Treatment Plan indicated tracheostomy suctioning two to three times daily and as needed by the ULP; however, the Special Instructions for Medications and Treatments indicated a schedule of times and every two hours as needed. The information did not match. R1's Treatment Plan lacked the treatment of	01940		

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01940	Continued From page 44 continuous oximetry and instructions for when the ULP should contact the nurse. On June 11, 2024, at 10:12 a.m. licensed assisted living/clinical nurse supervisor (LALD/CNS)-A indicated R1's CPT vest machine was preset to 30 minutes, and staff only needed to put the vest on, connect the tubing between the machine and the vest, and turn the machine on. The machine indicated 30 minutes when turned on. LALD/CNS-A indicated some of the information between R1's Treatment plan, Service Plan and Special Instructions did not match, and he would clarify the information. The licensee's Treatment and Therapy Management Plan policy dated February 7, 2023, indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided. b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services. e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube.	01960		

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01960	Continued From page 46 R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. R1's Service Plan lacked the services of oxygen, tracheostomy humidifier, continuous oximetry (a unit that measures the body's oxygen concentration via a sticky finger probe), and chest physiotherapy (CPT) vest device (worn over/around R1's chest/ribs to provide a mechanical means to loosen secretions in the lungs). On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's gastrostomy feeding tube. R1 was observed to have a pulse oximeter unit providing continual oxygen concentration measurements as attached to a finger. Additionally, the surveyor noted a mechanical device on R1's bedside table. ULP-B stated the device was a CPT vest worn twice daily. ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. ULP-B stated the staff were tasked to ensure R1's oxygen concentrator was always at four liters/minute, was humidified with the humidification machine and provided direct flow to R1' tracheostomy via a tracheostomy flow-by mask.	01960		

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01960	Continued From page 47 R1's Home Health Aide Care Plan dated October 1, 2023, indicated the following: -condom catheter change daily -Assistance with meals-G-tube-resident has G-tube -Treatments-Trach (tracheostomy) suctioning, vest treatment-see Treatment protocols/flowsheet R1' record included an undated, document labeled Special Instruction for Medication and Treatment which included: -Feeding-Isosource 1.5 at 60 cubic centimeters (cc) per hour over 24 hours daily, via feeding pump, with head of bed at 45-degree angle. -Water at 190 cc every three hours via feeding pump. Flush G-tube first thing every morning with 500 cc. Please check pump setting. -Suction: 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and every two hours when needed for increased secretion -Tracheostomy tube change monthly by nurse -connecting tubes- change twice monthly -condom catheter -change daily -urine bag change- twice per month -right foot boot should be on while in bed -Airway clearance therapy (CPT vest) twice daily a.m. and p.m. suction after therapy -oxygen- concentration at four liters while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater than 92%, turn oxygen off and turn on when in bed. -Humidifier to trach should be between three and four, make sure the pump is on, pump is in the bathroom. Hand wash filters in oxygen concentration and humidifier pump monthly. R1's record included an undated and unnamed, document that indicated:	01960		

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01960	Continued From page 48 -G-tube bag: change daily; -Condom catheter: change daily -Trach tube; change once a month; -Humidifier Chamber; biweekly; -oximetry sensor: change weekly -Urine bag: change every two weeks -Aerosol drainage: change every two weeks -Bacteria filter for suction: change once a month -Oxygen Tubing: change once a month The licensee failed to document the treatments/tasks identified in either document, as required. R1's Charting Sheet dated May 2024, included various tasks for staff to complete and document. The Charting Sheet included tracheostomy (trach) suctioning and CPT vest therapy; both shared the same line for documentation and lacked frequency for each treatment. Furthermore, R1's Charting Sheet included a section labeled "meal/plate Prep" with lines labeled "AM, Noon, and PM," with handwritten "G-tube". The document lacked specific task information as to what staff had completed. On June 11, 2024, at 10:20 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated the above listed tasks/treatments were completed by either staff or himself and had not been documented. He further stated he would create a treatment administration record for documentation of these treatments/tasks. The licensee's Treatment and Therapy Plan policy dated February 7, 2023, indicated each task (therapy or treatment) will be documented in the resident record. Each entry will include the signature and title of the person who	01960		

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01960	Continued From page 49 administered the treatment and will include the date and time of administration. Additionally, when the treatment or therapy is not administered as ordered, the facility will document the reason why it was not administered, communicate with prescriber as needed, and any follow up procedures that were provided to meet the resident need. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1, 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 a pattern scope (when more than a	01970		

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01970	Continued From page 50 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: R1 R1's diagnoses included non-traumatic intracranial hemorrhage (stroke) with right sided paralysis and presence of a tracheostomy with oxygen dependence, and gastrostomy feeding tube. R1's Service Plan dated October 2, 2023, indicated he received services to include medication administration, assistance with dressing, bathing, grooming, toileting (condom catheter management), transfers (Hoyer lift), gastric tube feedings, tracheostomy suctioning, blood sugar checks (weekly), and housekeeping. R1's Service Plan lacked the services of oxygen, tracheostomy humidifier, continuous oximetry (a unit that measures the body's oxygen concentration via a sticky finger probe), and chest physiotherapy (CPT) vest device (worn over/around R1's chest/ribs to provide a mechanical means to loosen secretions in the lungs). On June 10, 2024, at 12:24 p.m. unlicensed personnel (ULP)-B was observed to suction R1's tracheostomy. The surveyor observed R1 to have a tracheostomy mask (a cup like device placed close to a tracheostomy to deliver supplemental oxygen) with humidified oxygen flow of four liters/minute, a feeding pump with a bag of liquid feeding and another bag with water which infused a continuous flow of either feeding or water through R1's gastrostomy feeding tube. R1 was	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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 51 observed to have a pulse oximeter unit providing continual oxygen concentration measurements as attached to a finger. Additionally, the surveyor noted a mechanical device on R1's bedside table. ULP-B stated the device was a CPT vest worn twice daily. ULP-B stated R1 had history of a significant stroke leaving him paralyzed on the right side, unable to speak, and reliant on staff for all care. ULP-B stated the staff were tasked to ensure R1's oxygen concentrator was always at four liters/minute, was humidified with the humidification machine and provided direct flow to R1's tracheostomy via a tracheostomy flow-by mask. R1's provider orders dated October 20, 2023, indicated orders for Special Equipment/Supplies to include Humidifier pump and oximeter; however, the orders lacked the required content to include: a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Furthermore, the provider orders included an order for R1's CPT vest to be worn twice daily; however, the order lacked the duration of the CPT vest (30 minutes). On June 11, 2024, at 9:40 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A indicated he believed he had all orders for treatments in place, however, lacked the oximetry order and duration of CPT vest. LALD/CNS-A stated the CPT vest machine is preset to 30 minutes duration and the staff only must turn it on. R2 R2's diagnoses included congestive heart failure,	01970		

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	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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 52 kidney failure, and urinary incontinence. R2's Service Plan dated October 3, 2023, indicated she received the services of medication administration, assistance with dressing, bathing, haircare, nail/footcare, toileting, meal set up, compression stockings with lymphedema wraps, and housekeeping. On June 11, 2024, at 7:15 a.m. ULP-C was observed to don compression stockings and apply Velcro compression wraps to both of R2's lower extremities. ULP-C stated the compression stockings and Velcro wraps were put on in the morning and removed in the evening. R2's Treatment Plan (as part of the Service Plan), dated October 3, 2023, indicated lymphedema wraps with compression garments, daily times two. R2's Charting Sheet dated May 2024, indicated the treatment of "Velcro Wrap". R2's provider orders dated October 5, 2023, indicated Velcro wraps for lymphedema in both legs. The orders lacked the required content to include knee high compression stockings, and the frequency and duration of the treatment of both the compression stockings and Velcro wraps. On June 11, 2024, at 9:45 a.m. LALD/CNS-A indicated the wraps and stockings were worn during the day and removed at night, which was the intent of writing daily times two as part of the Treatment Plan. He further stated, the orders lacked knee high compression stockings and the duration of the treatment of both the compression stockings and Velcro wraps as required.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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 53 The licensee's Treatment and Therapy Management policy dated February 7, 2023, indicated the registered nurse (RN) or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided c. Frequency d. Other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) followed the proper steps with medication administration from pre-filled medication box for two of two residents (R2, R3). This practice resulted in a level two violation (a	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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
02320	Continued From page 54 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 R2's diagnoses included congestive heart failure, kidney failure, and urinary incontinence. R2's Service Plan dated October 3, 2023, indicated she received the services of medication administration. R2's provider orders dated October 2, 2023, indicated R2 received one medication for blood thinning, one topical antibiotic, one for heart rate control, one for dementia management, one eye drop for glaucoma, one for blood pressure, one antifungal for skin, and three supplements. R3 R3's diagnoses included primary hypertension. R3's Service Plan dated October 1, 2023, indicated he received the services of medication administration. R3's provider orders dated October 5, 2023, indicated R3 received one medication for acid reflux, three for blood pressure control, two supplements, two for allergies (one oral, one nasal spray), one for mild pain.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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
02320	Continued From page 55 On June 11, 2024, at 7:25 a.m. ULP-C was observed to remove two medication bins (R2, R3) from the medication cupboard. She removed a prefilled flip top medication box (with days of the week identified on each flip up tab) identified with R2's name. ULP-C identified R2 and stated, "Today is Tuesday, here are your morning medications." She poured the contents of Tuesday medication section into a medication cup and handed it to R2, who took the medications. The surveyor prompted ULP-C and asked, "How many tablets are you giving and what are the medications?" ULP-C stated, "There are seven pills." ULP-C continued with medication administration for R3. At 7:28 a.m. ULP-C was observed to take R3's preset pill box from R3's medication bin, she identified R3 and stated, "Today is Tuesday, here are your morning medications." ULP-C poured tablets from the pill box section labeled Tuesday into a medication cup and handed it to R3. R3 took the medications with his morning beverage. ULP-C set R3's nasal spray in front of him and stated, "He does the spray himself as we watch." When the surveyor asked ULP-C how many pills were being administered and what the pills were, ULP-C stated, "Five pills." ULP-C put the medication bins in the locked cabinet, washed her hands and went on to other tasks. ULP-C failed to reference the medication administration record (MAR) prior to medication administration and ensure the proper number of pills were administered, failed to reference what medications were to be given, and failed to immediately document medication administration for both R2 and R3 after medications were given. On June 11, 2024, at 7:45 a.m. licensed assisted living director/clinical nurse supervisor	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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02320	Continued From page 56 (LALD/CNS)-A stated the ULP were trained to always reference the resident's MAR prior to medication administration, count the number of tablets and at minimum tell the resident what the colors were and how many tablets were being administered. The licensee's procedure/protocol for Oral Medications dated September 29, 2023, indicated the ULP were to check the medication profile (MAR) for the right client, right day, right time, count number of pills for day/time and check for additional instructions. Furthermore, the ULP were to check the medication box for right client, right day, right time, and right number of pills for day/time. After ensuring medication administration, ULP to document on appropriate charting sheet (MAR). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *06/10/24*
Time: 11:13:03
Report: 1018241087

Food and Beverage Establishment Inspection Report

Location:
High Drive Custom Assisted Liv
13813 High Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: N039895
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

ESTABLISHMENT IS NOT CURRENTLY RECORDING INSTANCES OF VOMITING AND DIARRHEA IN KITCHEN EMPLOYEES. COMPLY WITH RULE.

Comply By: 06/10/24

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

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

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

EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. COMPLY WITH RULE.

Comply By: 06/10/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER PROVIDED IN ESTABLISHMENT DOES NOT HAVE SANITIZING FUNCTION AVAILABLE. COMPLY WITH RULE OR PROVE THAT CURRENT DISHWASHER CAN MEET

TEMPERATURE REQUIREMENTS FOR SANITIZING.
Comply By: 06/10/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CERTIFIED FOOD PROTECTION MANAGER ON SITE. COMPLY WITH RULE.
Comply By: 09/13/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
ESTABLISHMENT IS NOT CURRENTLY DOING SAME DAY SERVICE OF FOODS. DISCUSSED WITH STAFF THAT SINCE THE KITCHEN HAS RESIDENTIAL EQUIPMENT, ONLY SAME DAY SERVICE OF FOODS IS ALLOWED.
Comply By: 06/10/24

Food and Equipment Temperatures

Process/Item: Cold Holding/ COOLER
Temperature: 38 Degrees Fahrenheit - Location:
Violation Issued: No

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

EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

FLOORS, WALLS AND CEILINGS OBSERVED TO BE IN GOOD CONDITION

EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

2 BASIN SINK AVAILABLE FOR HAND WASHING AND FOOD PREP.

DISCUSSED PEST CONTROL.

Type: Full
Date: *06/10/24*
Time: 11:13:03
Report: 1018241087
High Drive Custom Assisted Liv

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 1018241087 of 06/10/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us