DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: HL32621002M
Compliance #: HL32621003C

Date Concluded: August 25, 2021

Name, Address, and County of Facility Investigated:
Uplifted Care Services LLC
3340 Brookdale Drive North
Brooklyn Park, MN 55443
Hennepin County

Name, Address, and County of Housing with Services location:
Uplifted Care Services LLC
7724 Abbott Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Home Care Provider

Investigator Name:
John Sheridan-Giese, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility neglected the client when facility staff did not complete safety checks. The facility also neglected the client when facility staff found the client unresponsive and did not perform cardio-pulmonary resuscitation (CPR).

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client had a diagnosis of paranoid schizophrenia and history of substance abuse. The facility was aware of the client's significant history of substance abuse, and accepted the client, even after the client was hospitalized after a drug overdose. After the client's hospitalization, the facility did not update the client's assessments and did not put additional safety interventions in place. The facility failed to provide safety checks and monitoring as indicated in the client's service plan.

The client was found unresponsive and facility staff failed to perform CPR, however, it was inconclusive whether the facility had an obligation to do so. The facility did follow their own policy, which was to stay with the unresponsive client and call 911. The client died of a fentanyl (synthetic opioid narcotic) overdose. The client's service plan indicated 911 would be called and CPR would be refrained if there was a physician's order for DNR. The client's records indicated the client desired a DNR but the facility lacked a physician's order.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed personnel (ULP). The investigator reviewed the client's records, staff schedules, personnel files, policies and procedures, hospital records, medical examiner records, court records, and law enforcement reports.

The client's medical diagnoses included paranoid schizophrenia, bipolar disorder, cannabis use disorder, and alcohol dependence. The client had a history of illicit drug use. The client's service plan included assistance with medication administration, activities of daily living (ADL) reminders, safety checks, and monitoring. The client's care plan included safety support and feelings of security provided by facility staff. The client was independent with ambulation and assessed as being alert and oriented to person, place, and time. The client's assessments indicated the client was unable to care for himself, dressed inappropriately, engaged in self-injurious behaviors, and sometimes neglected or refused to take medications.

Facility documentation indicated the director of nursing (DON) and administrator accepted the client to the facility with the knowledge of the client's significant substance abuse history. A few months after facility admittance, the client overdosed and was hospitalized. After the client's condition stabilized, the DON and administrator accepted the client back to the facility. The facility failed to put additional safety measures in place to protect the client from future overdoses.

One day, the client did not answer the door to his room for a routine safety check, which was to be conducted with each shift. The ULP knocked on the client's door but did not open the door to visualize the client. After approximately 6 hours of the client not answering his door, the ULP called the administrator. The administrator did not give the ULP instructions to open the client's door or to call 911 prior to the administrator's arrival. The administrator arrived approximately an hour later and attempted to open the client's bedroom door. The client's door was jammed shut with a butter knife. The client's door handle turned, but the door would not open. The administrator pushed the client's door in by force. The administrator observed the client on the floor, unresponsive and called 911. Emergency medical services (EMS) and law enforcement arrived. The client was pronounced deceased.

According to the client's death documentation, the client's immediate cause of death was fentanyl toxicity. The client's death was ruled accidental.

A 911 recording indicated the administrator called EMS and said the client did not answer his door and after forcefully entering the client's room, the administrator found the client unresponsive. The administrator indicated the client had passed out and was not breathing. The EMS dispatcher instructed the administrator to give the client CPR. The call was transferred to another EMS dispatcher who also instructed the administrator to give the client CPR. The administrator stated, "He's cold. He's not breathing." The EMS dispatcher stated, "Sir, if he's cold and not breathing, we need to start CPR." The administrator stated, "He is unresponsive." The administrator and ULP did not perform CPR.

Facility personnel documentation indicated the ULP, and administrator were both CPR certified at the time of the incident.

Facility documentation indicated in the weeks prior to the incident, the client was exhibiting increased behaviors. The client slept more, was not coming out his room and was locking his door by jamming it with a butter knife. There was no evidence indicating the facility notified the client's mental health providers regarding the client's behavior.

A law enforcement report indicated staff last observed the client the evening before the incident. The report also indicated the ULP working the day of the incident, had not seen (visualized) the client his entire shift, which had been six hours. The report further indicated the responding officer found the client cold and without a pulse. The administrator acknowledged the client was dependent on illicit drugs and the administrator believed the client mixed multiple illicit substances together to get high.

The client's facility medical records indicated the facility was to provide daily monitoring (including monitoring signs and symptoms for intoxication), safety checks, and housekeeping services (specifically to keep the clients environment clean). The facility records included the client was not able to manage and self-administer his own medications as the client indicated his medications were not working for him and he preferred to "get his own drugs from the street". The client's individual abuse prevention plan (IAPP) was not updated to reflect the client had a pending court case for assault and was not updated to assess the client's risk for self-harm or risk to other clients. The client's face sheet indicated, to provide all care necessary to keep the client alive. The client's comprehensive health assessment indicated the client was a full code (to perform CPR). The facility, however, had two health care directives on file for the client. The first, indicated the client was full-code and was not signed by the client. The second, indicated the client was a DNR (Do Not Resuscitate) but was not signed by the client's physician. The client's care plan was not updated with interventions after the client's drug overdose.

The client's court records indicated the client did not have the ability to understand and use information about his mental illness, symptoms, and treatment.

Facility policy indicated the facility's registered nurse accepted clients based on the client's needs and was responsible to determine if the facility possessed resources to adequately provide the

services agreed to in the client's service plan. Facility policy also indicated staff would respond to an unresponsive client by checking the client for evidence of breathing and a pulse, stay with the client, and call 911. The facility's advance directive policy indicated the DON would consult a client's medical provider after reviewing the advanced directives to obtain medical orders, and that advanced directives must be signed by a client with the mental capacity to do so and must contain the client's signature. There was no evidence of staff training on safety checks or any written documentation of what a safety check entailed.

During an interview, the ULP stated he worked the day of the incident and performed safety checks for the client by knocking on the client's door. The client did not respond verbally to the ULP's knocking on the client's door. The ULP said he was trained on how to carry out safety checks and knocking on the door was acceptable. The ULP said the client often left the facility at all hours of the day and night and staff was aware of the client's illegal drug use and said, "I did nothing for him", when asked what services were provided to the client. The ULP said he was unaware of the client's plan of care. On the day of the incident, the ULP did not open the door to check on the client and although he had keys to unlock the client's door, he did not use them. The ULP said the client had privacy rights and he followed facility policy by calling the administrator. The ULP said he called the administrator who pushed in the client's door and found the client unresponsive on the floor. The ULP said he did not, nor did the administrator, check the client for a pulse or perform CPR. The ULP said he was following facility policy by calling the administrator and not 911, and he did not initiate CPR because the administrator took charge of the incident upon his arrival.

During an interview, the DON said staff were to complete safety checks on the client by seeing (visualizing) the client and not just knocking on the client's door. The DON said after the incident, staff were retrained on how to complete safety checks correctly. The DON said he was responsible along with the administrator in accepting clients to the facility. The DON said he along with the administrator had concerns about being able to meet the client's needs and accepting the client back to the facility after the client overdosed on drugs and was hospitalized. The DON said he and the administrator accepted the client back to the facility because the client's condition stabilized at the hospital. The DON was not able to recall the safety interventions in place for the client, other than safety checks, or whether the client's plan of care lacked additional safety interventions.

During an interview, the administrator said he along with the DON had concerns regarding the client's drug usage prior to accepting the client to the facility. The administrator said it was decided to accept the client as the administrator and DON felt the facility was able to care for the client. The administrator said after the client overdosed, he and the DON discussed not accepting the client back to the facility as they were not able to meet the client's needs. The administrator said he decided to give the client one more chance based on the mission, vision, and values of the facility. The administrator said the client returned and continued to be non-complaint with the facility's alcohol and drug policies and the client continued to have impulse control issues.

The investigator attempted to interview the client's family. Law enforcement was not able to contact the client's family, and it was documented, the client was not close to his family. The family did not return the investigators phone calls.

In conclusion, neglect was substantiated against the facility.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) **reasonable and necessary** to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; **and**
(2) which is not the result of an **accident or therapeutic conduct**.
(b) The **absence** or likelihood of absence of care or services, including but **not limited to**, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which **a reasonable person** would deem **essential** to obtain or maintain the vulnerable adult's **health, safety, or comfort** considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. Deceased.
Family Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility: The facility indicated training was provided to staff regarding the correct way to perform safety checks, seeing (visualizing) the clients.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
Brooklyn Park Police Department
Hennepin County Attorney's Office

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32621	A. BUILDING: ____ B. WING ____	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFTED CARE SERVICES LLC	**3340 BROOKDALE DRIVE NORTH BROOKLYN PARK, MN 55443**

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On July 2, 2021, the Minnesota Department of Health initiated an investigation of complaint HL32621002M/HL32621003C. At the time of the survey, there were #4 clients receiving services under the comprehensive license. The following correction orders are issued for HL32621002M/HL32621003C, tag identification 0265, 0315, 0790, 0810, 0840, 0885, 1252, and 3800.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the investigators ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for licensing order follow-ups. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 265 SS=G	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice	0 265		

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Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights:
(2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two clients (C1) reviewed. C1 was found unresponsive and not breathing. Licensee staff failed to initiate Cardio-Pulmonary Resuscitation (CPR). C1 died at the licensee's facility.

This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

C1's medical record was reviewed. C1's medical diagnoses included asthma, bipolar disorder, schizophrenia, cannabis use disorder, and alcohol dependence. C1 history included illicit

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0 265	Continued From page 2 drug use. C1's health care directive dated, March 9, 2020, indicated C1 was a Full Code. C1's health care directive did not have C1's signature. C1's unsigned service plan dated March 9, 2020, indicated C1 required assistance with medication administration, activities of daily living (ADLs), daily reminders for C1 to start, perform, and complete self-care tasks, safety checks and monitoring. C1 was independent with walking. C1 was assessed as being alert and oriented to person, place, and time. C1's unsigned care plan dated March 9, 2020, indicated C1 required safety support and feelings of security to be provided by direct care staff. C1's health care directive dated May 3, 2020, indicated C1 selected Do Not Resuscitate (DNR). C1's health care directive did not have a physician's signature. The physician's signature section was left blank. C1's comprehensive health assessment dated February 24, 2021, was effective from February 28, 2021, to May 28, 2021, indicated C1's status was Full Code and noted C1 was known to abuse illicit and prescription medications. C1's face sheet, Medical Information, Emergency Orders, undated, indicated to provide all care necessary to keep C1 alive. C1's Order for Recommitment dated March 15, 2021, indicated C1 was recommitted as a person who posed a risk of harm due to a mental illness. C1's Order for Recommitment also indicated C1 did not have the ability to understand and use	0 265		

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information about his mental illness, symptoms, and treatment.

Licensee's internal investigation report dated March 29, 2021, indicated Director of Nursing (DON)-B spoke with C1 on numerous occasions regarding C1's chemical substance abuse. The report indicated the morning of March 27, 2021, staff performed safety checks on C1 by knocking on C1's bedroom door. C1 did not respond. Staff called the Administrator (ADM)-D. The report indicated ADM-D responded to the licensee and knocked on C1's bedroom door. C1 did not respond. ADM-D pushed against C1's bedroom door. ADM-D found C1 on the floor and unresponsive. ADM-D called 911. The police responded to the licensee along with the medical examiner. C1 was deceased. The report also indicated ADM-D found metallic pipes and a powdered substance in C1's bedroom. At the time of the licensee's internal investigation, the cause of death for C1 was unknown. There was no conclusion to the licensee's internal investigation.

C1's Minnesota Documentation of Death dated March 27, 2021, indicated C1's immediate cause of death was fentanyl toxicity.

Review of a 911 recording dated, March 27, 2021, at 1:39 p.m., indicated ADM-D called emergency medical services (EMS) and said C1 did not answer his door and ADM-D found C1 unresponsive. ADM-D indicated C1 passed out and was not breathing. The EMS dispatcher instructed ADM-D to administer CPR to C1. The 911 call was then transferred to another dispatcher who also instructed ADM-D to administer CPR to C1. ADM-D stated, "He's cold. He's not breathing." The dispatcher stated, "Sir, if

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0 265	Continued From page 4	0 265		

he's cold and not breathing, we need to start CPR." The dispatcher instructed ADM-D to get C1 flat on his back. ADM-D stated, "He is unresponsive." CPR was not initiated.

Review of ULP-A's personnel file on July 2, 2021, indicated ULP-A completed a Basic Life Support (BLS) course to learn CPR on March 2, 2021.

Review of ADM-D's personnel file on July 2, 2021, indicated ADM-D completed a BLS course to learn CPR on July 23, 2019.

Review of ULP-F's personnel file on July 2, 2021, indicated ULP-F did not complete a Basic Life Support (BLS) course.

Email correspondence dated July 16, 2021, to the evaluator from DON-B indicated the licensee did not have a copy of ULP-F's CPR certification; the licensee presumed ULP-F's certification expired.

During an interview on July 2, 2021, at 1:13 p.m., ULP-A said the day C1 died, he was responsible for C1's cares. ULP-A said he aware of C1's illicit drug use. ULP-A said he performed safety checks on C1 twice by knocking on C1's bedroom door. ULP-A said he carried a key for C1's door but did not open the door to check on C1. ULP-A stated he called ADM-D, and ADM-D arrived at the licensee, pushed in C1's door and found C1 unresponsive on the floor. ULP-A said he did not check for C1's pulse, and he did not perform CPR. ULP-A said ADM-D did not check for C1's pulse, and ADM-D did not perform CPR.

During an interview on July 2, 2021, at 3:10 p.m., DON-B said the licensee was aware of C1's substance abuse. DON-B said C1 was previously hospitalized for a drug overdose.

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DON-B said staff were supposed to complete safety checks twice per day. DON-B said staff were supposed to see C1 to check on him, not just knock on C1's door. DON-B said after C1's incident, the licensee provided additional training to staff regarding safety checks. DON-B said a formal training did not take place, and the licensee did not have documentation related to the training.

During an interview on July 6, 2021, at 1:01 p.m., ADM-D said staff were required to complete safety checks and indicated safety checks consisted of staff visualizing C1. ADM-D said he was CPR certified, and CPR certification was a requirement for employment with the licensee. ADM-D said he did not perform CPR on C1 when he found him unresponsive.

During an interview on July 9, 2021, at 8:00 a.m., ULP-F said she provided cared for C1 the night prior to his death. ULP-F said she did perform safety checks but did not actually see C1. ULP-F said she heard C1 make a noise and did not open the door to check on C1.

During an interview on July 9, 2021, at 9:00 a.m., Nurse Practitioner (NP)-G said she was C1's primary mental health provider since March 2020. NP-G said as a standard, C1 was supposed to have safety checks at least once per day.

During an interview on July 15, 2021, at 8:00 a.m., NP-H said she was C1's mental health provider since February 2021. NP-H said considering C1's diagnoses, safety checks (making sure C1 was conscious and aware) was vital for C1. NP-H said considering C1's previous overdose, CPR and Narcan (a drug to reverse opioid overdose) was essential for C1's survival.

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0 265	Continued From page 6 Licensee policy titled, Client Collapses or is Found Unresponsive, dated December 6, 2017, indicated staff should respond to an unresponsive client and checked for evidence of breathing and a pulse, stay with the client, and call 911. The policy also indicated staff should notify the 911 dispatcher about the condition of the client, such as no pulse or respirations. Licensee policy titled, Advance Directives, dated December 6, 2016, indicated the licensee's registered nurse (RN) should consult the client's attending medical providers after reviewing the client's advance directives. The policy also indicated an advance directive must be executed by a client with capacity to do so and must contain verification of the client's signature and include a health care instruction, a health care power of attorney, or both. The policy further indicated the licensee should be assisted by the client's medical provider to determine the client's capacity as required by law to execute the advance directive. The policy indicated a client's advance directive was to be communicated to the client's physician, and the licensee should request medical orders as appropriate, for example, using the POLST order form or the physician orders for DNR/DNI. Licensee policy titled, POLST ORDERS, dated December 6, 2016, indicated the licensee should work with the client's attending health care providers (physicians and nurse practitioners) to provide client services related to POLST orders. The policy also indicated the licensee's RN should ask the client and the client's attending health care provider if the client previously authorized POLST orders.	0 265		

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0 265	Continued From page 7 No further documentation was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 265		
0 315 SS=G	144A.44, Subd. 1(a)(12) Served by People Who Are Competent Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (12) be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure clients were served by staff who were properly trained and competent for one of two clients (C1) reviewed. The licensee failed to ensure unlicensed staff were properly trained in providing safety checks to clients. After C1 was admitted to the hospital for a drug overdose, C1 returned to the licensee's establishment, and the licensee's staff did not perform safety checks according to facility policy. The licensee also failed to ensure staff were properly trained in Cardio-Pulmonary Resuscitation (CPR). After C1 was found unresponsive in his room, staff did not perform CPR.	0 315		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFTED CARE SERVICES LLC	3340 BROOKDALE DRIVE NORTH BROOKLYN PARK, MN 55443

(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
0 315	Continued From page 8	0 315		

This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings include:

C1's medical record was reviewed. C1's medical diagnoses included asthma, bipolar disorder, schizophrenia, cannabis use disorder, and alcohol dependence. C1 had a history of illicit drug use.

C1's medication administration record was reviewed. C1's medications included Invega Sustenna injection and Olanzapine by mouth for C1's diagnosis of schizophrenia.

C1's unsigned service plan dated March 9, 2020, indicated C1 required assistance with medication administration, activities of daily living (ADLs), daily reminders for C1 to start, perform, and complete self-care tasks, safety checks and monitoring. C1 was independent with walking. C1 was assessed as being alert and oriented to person, place, and time.

C1's unsigned care plan dated March 9, 2020, indicated C1 required safety support and feelings of security to be provided by direct care staff.

C1's health care directive dated March 9, 2020, indicated C1 was a Full Code. C1's health care directive did not have C1's signature.

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C1's health care directive dated May 3, 2020, indicated C1 selected Do Not Resuscitate (DNR). C1's health care directive did not have a physician's signature. The physician's signature section was left blank.

C1's comprehensive health assessment dated February 24, 2021, was effective from February 28, 2021 to May 28, 2021, indicated C1's status was Full Code and noted C1 was known to abuse illicit and prescription medications.

C1's face sheet, Medical Information, Emergency Orders, undated, indicated to provide all care necessary to keep C1 alive.

The licensee's internal investigation report dated March 29, 2021, indicated Director of Nursing (DON)-B had numerous conversations with C1 regarding C1's chemical substance abuse. The report indicated the morning of March 27, 2021, staff performed safety checks on C1 by knocking on C1's bedroom door. C1 did not respond. Staff called the Administrator (ADM)-D. The report indicated ADM-D responded to the licensee and knocked on C1's bedroom door. C1 did not respond. ADM-D pushed against C1's bedroom door. ADM-D found C1 on the floor unresponsive. ADM-D called 911. The police responded to the licensee along with the medical examiner. C1 was deceased. The report also indicated ADM-D found metallic pipes and a powdered substance in C1's bedroom. At the time of the licensee's internal investigation, the cause of death for C1 was unknown. There was no conclusion to the licensee's internal investigation.

C1's Minnesota Documentation of Death dated March 27, 2021, indicated C1's immediate cause of death was fentanyl toxicity.

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0 315	Continued From page 10 Review of a 911 recording dated March 27, 2021, at 1:39 p.m., indicated ADM-D called emergency medical services (EMS) and said C1 did not answer his door, and ADM-D found C1 unresponsive. ADM-D indicated C1 passed out and was not breathing. The EMS dispatcher instructed ADM-D to give C1 CPR. The call was then transferred to another 911 dispatcher who also instructed ADM-D to give C1 CPR. ADM-D stated, "He's cold. He's not breathing." The dispatcher stated, "Sir, if he's cold and not breathing, we need to start CPR." The dispatcher instructed ADM-D to get C1 flat on his back. ADM-D stated, "He is unresponsive." CPR was not initiated. Review of ULP-A's personnel file on July 2, 2021, indicated ULP-A completed a Basic Life Support (BLS) course for CPR on March 2, 2021. Review of ADM-D's personnel file on July 2, 2021, indicated ADM-D completed a Basic Life Support (BLS) course for CPR on July 23, 2019. Review of ULP-F's personnel file on July 2, 2021, indicated there was no documentation ULP-F completed a Basic Life Support (BLS) course. In an email dated July 16, 2021, DON-B indicated the licensee did not have a copy of ULP-F's CPR certification, and the licensee presumed ULP-F's certification expired. During an interview on July 2, 2021, at 1:13 p.m., unlicensed personnel (ULP)-A said he was responsible for C1's cares; he worked the day of C1's death and was aware of C1's illicit drug use. ULP-A said he performed safety checks on C1 twice by knocking on C1's bedroom door. ULP-A	0 315		

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0 315	Continued From page 11	0 315		

said he carried a key for C1's door and did not open the door to check on C1. ULP-A called ADM-D. ADM-D arrived at the licensee, and ADM-D pushed in C1's door and found C1 unresponsive on the floor. ULP-A said he did not check for C1's pulse, and he did not perform CPR. ULP-A said ADM-D did not check for C1's pulse, and ADM-D did not perform CPR.

During an interview on July 2, 2021, at 3:10 p.m., DON-B said the licensee was aware of C1's substance abuse. DON-B said C1 was previously hospitalized for a drug overdose. DON-B said licensee staff were trained to complete safety checks twice per day. DON-B said staff were trained to at least hear C1 in his room as an acceptable safety check. DON-B said after C1's death, the licensee provided additional training to staff regarding safety checks, and staff were now expected to see (visualize) clients. DON-B said a formal training did not take place, and the licensee did not have documentation related to the training.

During an interview on July 6, 2021, at 1:01 p.m., ADM-D said C1 required safety checks, and safety checks consisted of staff seeing C1. ADM-D said he was CPR certified, and the licensee required CPR certification. ADM-D said he did not perform CPR on C1.

During an interview on July 9, 2021, at 8:00 a.m., ULP-F said she cared for C1 the night prior to C1's death. ULP-F said she performed safety checks, but did not see C1. ULP-F said she heard C1 make a noise, but did not open the door to check on C1.

During an interview on July 9, 2021, at 9:00 a.m., Nurse Practitioner (NP)-G said she was C1's

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0 315	Continued From page 12 primary mental health provider since March 2020. NP-G said as a standard, C1 was to have safety checks at least once per day. During an interview on July 15, 2021, at 8:00 a.m., NP-H said she was C1's mental health provider since February 2021. NP-H said considering C1's diagnoses, safety checks (making sure C1 was conscious and aware) were vital for C1. NP-H said considering C1's previous overdose, CPR and Narcan (a drug to reverse opioid overdose) was essential for C1's survival. Licensee policy titled, Training and Competency Evaluation of Unlicensed Staff, dated December 6, 2016, indicated the licensee's Registered Nurse (RN) determined if unlicensed staff competently performed all assigned tasks and services to home care clients. The policy indicated unlicensed staff were trained in procedures in handling emergency situations and observation, reporting and documenting the client's status. The policy also indicated the RN developed and maintained a system to track the training and competency of all unlicensed staff. Licensee policy titled, Supervision of Licensed and Unlicensed Personnel, dated December 6, 2016, indicated the licensee's unlicensed staff was to be supervised by designated supervisors to ensure staff performed their job duties, competently, consistently, and professionally. The policy also indicated the supervisors identified orientation needs of staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 315		

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0 790	Continued From page 13	0 790		
0 790 SS=F	144A.479, Subd. 3 Quality Management Subd. 3.Quality management. The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct quality management activities appropriate to the size of the home care provider and relevant to the type of services the licensee provided. The licensee failed to evaluate the quality of care and determine whether changes in services or other procedures are needed to ensure safe and competent services. The licensee also failed to complete an annual quality management plan. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 790		

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0 790	Continued From page 14 or has the potential to affect a large portion or all of the clients). Findings Include: The Centers for Medicare and Medicaid Services (CMS) website, Quality Assurance and Performance Improvement (QAPI) Guidelines section, indicated effective quality management programs are critical to improving quality of life, quality of care, and services to clients. Review of the licensee's Quality Management Evaluation and Program Involvement Plan, undated, indicated the licensee did not evaluate care or procedures to ensure safe and competent services are being offered to clients. The licensee did not provide any agendas or meeting minutes. The licensee did not provide quality management documentation for the last two years. During an interview on July 2, 2021, at 10:26 a.m., Director of Nursing (DON)-B said he is the licensee's designated manager for the licensee's quality management program. DON-B said the licensee meets quarterly and as needed to conduct quality management activities. DON-B said the licensee did not keep written minutes of meetings. DON-B did not provide any additional documentation. Licensee policy titled, Quality Improvement Project, revised date, December 8, 2017, indicated the licensee conducted at least one documented quality improvement project. The policy also indicated the licensee retained records of quality management projects for at least two years. The policy further indicated the licensee's performance improvement documentation was available upon request to MDH surveyors and	0 790		

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0 790	Continued From page 15 investigators. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 790		
0 810 SS=F	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) for one of two clients (C1) reviewed. After C1 was hospitalized for a drug overdose, the licensee discovered C1 had a pending court case for assault. C1's IAPP was not updated to assess C1's risk for self-harm or C1's risk to other clients at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 16	0 810		

client'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 clients).

Findings include:

C1's medical record was reviewed. C1's medical diagnoses included asthma, bipolar disorder, schizophrenia, cannabis use disorder, and alcohol dependence. C1 had a history of illicit drug use.

C1's unsigned service plan dated March 9, 2020, indicated C1 required assistance with medication administration, activities of daily living (ADLs), reminders, safety checks and monitoring. C1 was independent with walking. C1 was assessed as being alert and oriented to person, place, and time.

C1's unsigned care plan dated March 9, 2020, indicated C1 required safety support and feelings of security to be provided by direct care staff.

C1's unsigned IAPP dated March 10, 2020, indicated C1 was assessed as vulnerable for self-abuse related to C1's inability to care for self-help needs; C1 neglected or refused to take medications.

Licensee's internal investigation report dated March 29, 2021, indicated Director of Nursing (DON)-B and C1 discussed C1's substance abuse on multiple occasions. The report indicated the morning of March 27, 2021, staff performed safety checks/monitoring on C1 by knocking on C1's bedroom door. C1 did not respond. Staff called the Administrator (ADM)-D. The report

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0 810	Continued From page 17	0 810		

indicated ADM-D responded to the licensee and knocked on C1's bedroom door. C1 did not respond. ADM-D pushed against C1's bedroom door. ADM-D found C1 on the floor unresponsive. ADM-D called 911. The police and ambulance responded to the licensee along with the medical examiner. C1 was pronounced deceased. The report also indicated ADM-D found metallic pipes and a powdered substance in C1's bedroom. At the time of the licensee's internal investigation report, the cause of death was unknown. There was no conclusion to the licensee's internal investigation.

During an interview on July 2, 2021, at 3:10 p.m., DON-B said C1 was admitted to the licensee, and the licensee was aware of C1's substance abuse. DON-B said C1, when initially admitted, stayed for three weeks and then left. When C1 returned, DON-B and other staff noticed C1 with symptoms of substance abuse. DON-B said C1 was hospitalized for a drug overdose. DON-B said he communicated with the hospital, and C1's condition stabilized. DON-B said the decision was made to accept C1 back to the licensee's establishment. DON-B said the licensee was aware of C1's pending court case for assault with possible criminal charges.

C1's IAPP was not updated to reflect C1's hospitalization for a drug overdose with interventions. C1's IAPP was not updated to reflect the licensee was aware C1 was capable of physical aggression towards others.

Licensee policy titled, Initial and On-Going Nursing Assessment of Clients Under the Comprehensive Licensed Agency, dated, December 6, 2016, indicated the licensee's registered nurse (RN) reassessed the client and

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0 810	Continued From page 18 updated the service plan based on the client's needs. The policy also indicated the RN assessed the client's areas of vulnerability and susceptibility to maltreatment and whether the client posed a risk to other vulnerable adults. The policy also indicated the RN would develop a service plan which addressed the client's needs and included interventions necessary to reduce the client's risk of maltreatment or to reduce to the risk the client posed to other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
0 840 SS=G	144A.4791, Subd. 4 Acceptance of Clients Subd. 4.Acceptance of clients. No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have staff sufficient in qualifications and competency to adequately provide services agreed to for one of two clients (C1) reviewed. C1 was readmitted to the licensee after C1's hospitalization for a drug overdose. Licensee's staff received minimal to no training regarding mental health, substance abuse, and behavioral health to address C1's monitoring and safety needs. Licensee's staff were aware of C1's continued illicit drug use at	0 840		

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the facility; C1 subsequently died of a fentanyl overdose while at the facility.

This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings Include:

C1's medical record was reviewed. C1's medical diagnoses included asthma, bipolar disorder, schizophrenia, cannabis use disorder, and alcohol dependence. C1 had a history of illicit drug use.

C1's unsigned service plan dated March 9, 2020, indicated C1 required assistance with medication administration, activities of daily living (ADLs), daily reminders for C1 to start, perform, and complete self-care tasks, safety checks, and monitoring. C1 was independent with walking. C1 was assessed as being alert and oriented to person, place, and time.

C1's unsigned care plan dated March 9, 2020, indicated C1 required safety support and feelings of security to be provided by direct care staff.

C1's medication administration record was reviewed. C1's medications included Invega Sustenna injection and Olanzapine by mouth, both indicated for C1's diagnosis of schizophrenia.

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0 840	Continued From page 20	0 840		

The licensee's internal investigation report dated March 29, 2021, indicated Director of Nursing (DON)-B had numerous conversations with C1 regarding C1's substance abuse. The report indicated the morning of March 27, 2021, staff performed safety checks on C1 by knocking on C1's bedroom door. C1 did not respond. Staff called the Administrator (ADM)-D. The report indicated ADM-D responded to the licensee and knocked on C1's bedroom door. C1 did not respond. ADM-D pushed against C1's bedroom door. ADM-D found C1 on the floor unresponsive. ADM-D called 911. The police and ambulance responded to the licensee along with the medical examiner. C1 was deceased. The report also indicated ADM-D found metallic pipes and a powdered substance in C1's bedroom. At the time of the licensee's internal investigation, the cause of death for C1 was unknown. There was no conclusion to the licensee's investigation.

C1's health care directive dated March 9, 2020, indicated C1 was a Full Code. C1's health care directive did not have C1's signature.

C1's health care directive dated May 3, 2020, indicated C1 selected, Do Not Resuscitate (DNR). C1's health care directive did not have a physician's signature. The physician's signature section was left blank.

C1's comprehensive health assessment dated February 24, 2021, was effective from February 28, 2021, to May 28, 2021, indicated C1's status was Full Code and C1 was known to abuse illicit and prescription medications.

C1's face sheet, Medical Information, Emergency Orders, undated, indicated to provide all care necessary to keep C1 alive.

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C1's Order for Recommitment dated, March 15, 2021 indicated C1 was recommitted as a person who posed a risk of harm due to a mental illness. C1's order also indicated C1 did not have the ability to understand and use information about his mental illness, symptoms, and treatment.

C1's Minnesota Documentation of Death dated, March 27, 2021, indicated C1's immediate cause of death was fentanyl toxicity.

A review of a 911 recording dated, March 27, 2021, at 1:39 p.m., indicated ADM-D called emergency medical services (EMS) and said C1 did not answer his door, and ADM-D found C1 unresponsive. ADM-D indicated C1 passed out and was not breathing. The EMS dispatcher instructed ADM-D to give C1 CPR. The call was transferred to another dispatcher who also instructed ADM-D to give C1 CPR. ADM-D stated, "He's cold. He's not breathing." The dispatcher stated, "Sir, if he's cold and not breathing, we need to start CPR." The dispatcher instructed ADM-D to get C1 flat on his back. ADM-D stated, "He is unresponsive." CPR was not initiated.

A review of unlicensed personnel (ULP)-A's personnel record on July 2, 2021, indicated ULP-A received online training via the licensee's EduCare platform on behavioral health and substance abuse. There was no documentation ULP-A received training in mental health.

A review of ULP-F's personnel record on July 2, 2021, showed no documentation ULP-F received training in behavioral health, substance abuse, or mental health.

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0 840	Continued From page 22 A review of ULP-I's personnel record on July 2, 2021, showed ULP-I did not receive training in behavioral health, substance abuse, or mental health. During an interview on July 2, 2021, at 1:13 p.m., unlicensed personnel (ULP)-A said he was responsible for C1's cares; he worked the day of C1's death and was aware of C1's illicit drug use. ULP-A said C1 often left the licensee's premises. On the day of C1's death, ULP-A said he performed safety checks on C1 twice by knocking on C1's bedroom door. ULP-A said he carried a key for C1's door, but did not open the door to check on C1. ULP-A called ADM-D. ADM-D arrived at the licensee and ADM-D pushed in C1's door and found C1 unresponsive on the floor. ULP-A said he did not check for C1's pulse and he did not perform CPR. ULP-A said ADM-D did not check for C1's pulse, and ADM-D did not perform CPR. During an interview on July 2, 2021, at 3:10 p.m., DON-B said C1 was admitted to the licensee, and the licensee was aware of C1's substance abuse. DON-B said C1, when initially admitted, stayed for three weeks, and then left. DON-B stated when C1 returned to the licensee he noticed C1 was under the influence. DON-B said C1 was later hospitalized for a drug overdose. DON-B said he was concerned about C1 returning to the licensee. DON-B accepted C1 back to the licensee due to C1's stabilized condition. DON-B said staff were supposed to complete C1's safety checks twice per day. DON-B said staff was supposed to see C1 to check on him, not just knock on C1's door. DON-B said after C1's death, additional staff training was provided to staff regarding safety checks.	0 840		

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During an interview on July 6, 2021, at 1:01 p.m., ADM-D said he and DON-B accepted C1 as a client. ADM-D said he was concerned about C1's substance abuse issues, and the possibility the licensee was not able to meet C1's needs. ADM-D said after C1 was hospitalized for a drug overdose, ADM-D and DON-B decided to accept him back to the licensee's establishment. ADM-D said C1 required safety checks, and safety checks consisted of staff seeing C1. ADM-D said he was CPR certified, and CPR certification was a requirement for employment with the licensee. ADM-D said he did not perform CPR on C1. ADM-D said he recalled C1 was a DNR, and C1 did not have a Provider Order for Life Sustaining Treatment (POLST) on file.

During an interview on July 9, 2021, at 8:00 a.m., ULP-F said she worked with C1 the night prior to his death. ULP-F said she performed safety checks, but did not see C1. ULP-F said she heard C1 make a noise, but ULP-F did not open the door to check on C1. ULP-F said after C1's death, the licensee provided additional training to staff.

During an interview on July 9, 2021, at 9:00 a.m., Nurse Practitioner (NP)-G said she was C1's primary mental health provider since March 2020. NP-G said as a standard, C1 was to have safety checks at least once per day. NP-G said she was unaware of C1's code status, and C1 did not have a terminal diagnosis. NP-G said she was C1's primary care provider and would expect the licensee to notify her of a code status change. NP-G said she was surprised C1 was a DNR and did not learn of C1's death until she was called to be interviewed by the MDH surveyor.

During an interview on July 15, 2021, at 8:00

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a.m., NP-H said she was C1's mental health provider since February of 2021. NP-H said considering C1's diagnoses, safety checks (making sure C1 was conscious and aware) were vital for C1. NP-H said the licensee did not notify her regarding C1's code status change to DNR. NP-H said considering C1 previous overdose, CPR and Narcan (a drug to reverse opioid overdose) was essential for C1's survival.

C1's medical record did not contain a provider's order for Narcan.

Licensee policy titled, Admission Process for New Clients, dated January 2020, indicated the licensee's Registered Nurse (RN) determined acceptance of new clients, based on the client's needs, staffing levels, staff qualifications, and competencies. The policy indicated the RN was to determine if the licensee possessed adequate resources within the licensee's scope of practice consistent with the housing with services license, to adequately provide the services agreed to in the client's service plan.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) Days.

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0 885 SS=F	144A.4791, Subd. 12 Disaster/Emergency Preparedness Planning	0 885		

Subd. 12.Disaster planning and emergency preparedness plan. The home care provider must have a written plan of action to facilitate the management of the client's care and services in response to a natural disaster, such as flood and storms, or other emergencies that may disrupt

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the home care provider's ability to provide care or services. The licensee must provide adequate orientation and training of staff on emergency preparedness.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop a written plan of action for management of client care and services in response to a natural disaster. A natural disaster would include flood, storms, or other emergencies that may disrupt the licensee's ability to provide care and services to all clients served.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).

Findings Include:

During an interview on July 2, 2021, at 10:26 a.m., Director of Nursing (DON)-B said the licensee's natural disasters and emergencies policy is the licensee's written emergency disaster plan.

During an interview on July 27, 2021, at 1:48 p.m., DON-B said the policy already provided was the only document which addressed a written plan of action for disaster management. DON-B did not provide any further information.

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0 885	Continued From page 26 In an email correspondence to the MDH surveyor dated July 27, 2021, at 5:12 p.m., DON-B provided additional documentation to the MDH surveyor, but the documentation did not include a natural disaster or emergency disaster plan. Licensee policy titled, Plans for Natural Disasters and Emergencies, dated and signed, December 9, 2016, indicated the licensee was to have a written plan of action to facilitate client's care in response to a natural disaster or another type of emergency. The policy indicated the plan was to be updated regularly and was to be coordinated with local emergency responders. The policy further indicated the licensee was to have a written emergency disaster plan for evacuation, addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or emergency. The policy also indicated an emergency disaster plan was to be prominently posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	0 885		
01252 SS=F	144A.4798, Subd. 3 Infection Control Program Subd. 3.Infection control program. A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control. This MN Requirement is not met as evidenced by:	01252		

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Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control with hand hygiene.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the potential to affect a large portion or all of the clients).

Findings Include:

HAND HYGIENE/GLOVES

The licensee failed to ensure staff performed hand hygiene according to the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) guidelines.

The CDC document titled, Interim Infection and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated December 14, 2020, indicated healthcare personnel (HCP) should perform hand hygiene (HH) before and after all patient contact, contact with potentially infectious material, and before donning and doffing personal protective equipment (PPE), including gloves. The CDC recommended alcohol-based hand sanitizer (ABHR) with 60% to 95% alcohol, or washing hands with soap and water for at least 20 seconds.

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During an observation on July 2, 2021, at 9:00 a.m., an MDH surveyor arrived at the licensee's establishment. Upon entering, the surveyor observed an empty hand sanitizer machine attached to the licensee's wall. Unlicensed Personnel (ULP)-A greeted the MDH surveyor at the entrance. ULP-A said the licensee did not keep a record of staff who was supposed to check and refill the hand sanitizer machine.

During an observation on July 2, 2021, at 9:28 a.m., ULP-A prepared food in the kitchen for all clients. ULP-A did not perform HH before preparing the food and did not wear gloves.

During an observation on July 2, 2021, at 10:12 a.m., House Manager (HM)-E arrived to deliver food to the licensee. HM-E did not perform HH upon entering or exiting the licensee.

During an observation on July 2, 2021, at 10:29 a.m., Director of Nursing (DON)-B assisted a client with a hang nail. DON-B did not perform HH and did not wear gloves.

During an observation on July 2, 2021, at 10:40 a.m., the MDH surveyor asked DON-B for a list of documents. DON-B did not perform HH prior to exiting the licensee's establishment to retrieve the documents.

During an observation on July 2, 2021, at 12:08 p.m., C2 complained of stomach pain. DON-B assessed C2 and used a stethoscope and auscultated C2's abdomen. DON-B did not perform HH and did not wear gloves.

During an interview on July 2, 2021, at 10:03 a.m., ULP-A said the licensee provided infection

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control and HH training.

During an interview on July 2, 2021, at 3:10 p.m., DON-B said he managed the licensee's nursing operations. DON-B said he was responsible for infection control and COVID-19 training. DON-B stated all staff received training.

Licensee policy titled, Infection Control: Preventing the Spread of COVID-19, updated June 20, 2020, indicated hand hygiene was the single most effective way to control the spread of infection. The licensee's policy indicated gloves did not replace hand washing and HH was performed before and after direct contact with a client.

Licensee policy titled, Infection Control: Standard Precautions, updated April 20, 2020, indicated the licensee followed the guidance of the CDC and MDH. The policy indicated HH was performed before and after direct contact with a client. The policy also indicated the licensee's staff used gloves before direct contact with a client.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

The licensee failed to ensure staff donned personal protective equipment (PPE) properly during routine encounters.

The MDH document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, updated March 8, 2021, indicated direct care staff should wear appropriate PPE (including masks) during all client care encounters as utilizing appropriate PPE reduces staff exposure to COVID-19. In addition, the MDH document recommended all staff wear a well-fitted mask (fully covers the mouth and nose) at all times.

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The CDC document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated December 14, 2020, indicated staff who worked in areas with moderate to substantial community transmission were more likely to encounter asymptomatic or pre-symptomatic clients with COVID-19. The guidance indicated healthcare personnel (HCP) who worked with clients suspected or confirmed SARS-CoV-2 infection adhere to standard precautions and use appropriate PPE, including properly fitted masks.

During an observation on July 2, 2021, at 9:00 a.m., a MDH surveyor entered the licensee's establishment and was greeted by ULP-A; ULP-A was not wearing a mask.

During an observation on July 2, 2021, at 10:26 a.m., DON-B arrived at the licensee to meet the MDH surveyor. DON-B did not wear a mask. DON-B applied a mask after DON-B walked through the licensee's establishment and after interacting with staff and clients.

During an observation on July 2, 2021, at 11:24 a.m., Administrator (ADM)-D arrived at the licensee to meet the MDH surveyor. ADM-D did not wear a mask. ADM-D applied a mask after ADM-D walked through the licensee's establishment and after interacting with staff and clients.

During an interview on July 2, 2021, at 10:03 a.m., ULP-A said the licensee provided COVID-19 training.

During an interview on July 2, 2021, at 3:10 p.m.,

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01252	Continued From page 31 DON-B said he managed the licensee's nursing operations. DON-B said he was responsible for infection control and COVID-19 training. Licensee policy titled, Infection Control: Standard Precautions, updated April 20, 2020, indicated the licensee followed the guidance of the CDC and MDH related to COVID-19 and PPE. The policy indicated PPE procedures applied to all licensee staff. The policy also indicated masks to be worn with client contact. Licensee policy titled, Infection Control: Preventing the Spread of COVID-19, dated, June 20, 2020, indicated all staff should wear a face mask. SCREENING of VISITORS The licensee failed to immediately screen visitors and staff for fever and COVID-19 symptoms upon entering the facility per Minnesota Department of Health (MDH) guidelines. The MDH COVID-19 Toolkit, Information for Long-Term Care Facilities, updated March 8, 2021, indicated the greatest risk of COVID-19 entering a facility is the movement of persons in and out. The toolkit indicated licensees should screen and restrict visitors who have symptoms of COVID-19. The toolkit also indicated licensees should screen all staff for fever and symptoms of illness before starting each shift. During an observation on July 2, 2021 at 9:00 a.m., a MDH surveyor entered the licensee's establishment and was greeted by ULP-A. ULP-A did not screen the surveyor for COVID-19 symptoms. ULP-A said he was happy seeing the MDH surveyor and forgot to do the screening.	01252		

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During an observation on July 2, 2021 at 10:12 a.m., the MDH surveyor asked ULP-A for a copy of the staff sign-in sheet and COVID-19 questionnaire. ULP-A said all staff self-screen prior to the start of their assigned shift. ULP-A said COVID-19 information was placed on a yellow legal pad of paper and then sent to corporate. ULP-A did not provide a COVID-19 questionnaire. The MDH surveyor noticed the yellow legal pad for the day's symptoms was blank, indicating ULP-A did not self-screen for COVID-19 symptoms. ULP-A said he did not screen himself. ULP-A said he arrived to work at 7:00 a.m.

During an interview on July 2, 2021, at 10:03 a.m., ULP-A said all visitors were to be screened, information entered on a yellow legal pad and sent to the licensee's corporate office daily. ULP-A said he entered COVID-19 visitor information into the licensee's computer system. ULP-A said he received COVID-19 training provided by the licensee.

During an interview on July 2, 2021, at 3:10 p.m., DON-B said staff were supposed to screen all visitors. DON-B said visitor information was to be entered into the client's chart. DON-B did not show the MDH surveyor where visitor information was captured in the computer system. DON-B showed the MDH surveyor the client's chart information where COVID-19 screening is captured for daily screening of the clients.

Licensee policy titled, Infection Control: Preventing the Spread of COVID-19 dated, June 20, 2020, indicated staff would check for the presence or absence of COVID-19 symptoms on themselves and every visitor and document the

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results.

CLEANING AND DISINFECTING

The licensee failed to properly clean and disinfect frequently touched surfaces to prevent the spread of COVID-19 according to MDH guidelines.

The MDH COVID-19 Toolkit, Information for Long-Term Care Facilities, updated March 8, 2021, indicated frequently touched services such as door handles, bathroom surfaces, and hand rails should be cleaned at least daily. The toolkit also indicated facilities to disinfect surfaces with an environmental protection agency (EPA) registered disinfectant which indicated effectiveness against human coronavirus or emerging viral pathogens.

During an observation on July 2, 2021, at 9:00 a.m., there was no daily cleaning log observed as posted detailing when high touch surface areas were cleaned and how often.

During an interview on July 2, 2021, at 10:03 a.m., ULP-A said staff cleaned living areas, but did not follow a written cleaning schedule. ULP-A said the licensee did not employ housekeeping or maintenance staff so ULP staff were responsible for cleaning. ULP-A said clients were responsible for cleaning their own rooms. ULP-A said the licensee used Lysol disinfectant spray to disinfect areas. ULP-A did not know which specific type of cleaning product the licensee used for COVID-19 nor the contact time in which the disinfectant was effective.

Licensee's policy titled, Infection Control - COVID -19 and Droplet Precautions, undated, indicated the licensee followed CDC and MDH guidelines

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32621	A. BUILDING: ______ B. WING ______	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPLIFTED CARE SERVICES LLC	**3340 BROOKDALE DRIVE NORTH BROOKLYN PARK, MN 55443**

(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
01252	Continued From page 34 for COVID-19 prevention. The policy indicated the licensee followed cleaning and disinfecting policies as related to the prevention of COVID-19. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days.	01252		
03800 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice related to electronic monitoring devices was posted at each entrance of the establishment. This had the potential to affect the clients (C1, C2), all other clients, staff, and any visitors to the licensee's establishment. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 clients).	03800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03800	Continued From page 35 Findings include: On July 2, 2021, at 9:00 a.m., a MDH surveyor arrived at the licensee and observed the required sign reading, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities" was not posted at the facility entrance accessible to visitors. During an interview on July 2, 2021, at 10:30 a.m., Director of Nursing (DON)-B said he did not know signage was required. During an interview on July 2, 2021, at 4:00 p.m., Administrator (ADM)-D said he did not know signage was required. The licensee did not have a policy regarding electronic monitoring devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	03800		