STATE LICENSING COMPLIANCE REPORT

Report #: HL33169006C

Date Concluded: June 1, 2022

Name, Address, and County of Facility Investigated:
The Harbors Senior Living Fridley
5300 4th Street NE
Minneapolis, MN 55421
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Carrie Euerle MSN, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33169	A. BUILDING: _____ B. WING _____	C 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRID	5300 4TH STREET NE FRIDLEY, MN 55421

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: HL33169006C, HL33169007M/HL33169008C and HL33169009C On April 12, 2022 through April 13, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL33169006C, HL33169007M/HL33169008C and HL33169009C, tag identification 0460, 1640, and 1760.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week for 1 of 1 (R1) residents reviewed. During a period of less than three weeks, the licensee failed to answer R1's call light within 40 minutes on multiple occasions, including at least ten occasions where the call light response time was over an hour. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	0 460	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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	

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0 460	Continued From page 2 only occasionally). Findings include: R1's signed service agreement, dated February 8, 2022, indicated R1 received services for mobility, toileting, transfer and bathing assistance. The service plan indicated R1 required physical assist of one staff member to complete these tasks. The service plan further indicated R1 required escort assistance to meals and activites and every two hour safety checks. Review of documentation provided by the facility included call light audit times for the dates of March 25 to April 13, 2022. The executive director (ED) of the facility indicated, on April 13, 2022, at 3:25 p.m. the facility was unable to provide call light audits prior to March 25, 2022 due to a system malfunction. The call light audit from March 25, 2022, through April 13, 2022 included the following call light wait times that were over 40 minutes: -March 25, 2022, at 6:36 p.m. to 8:22 p.m. for a total of 105 minutes -March 26, 2022 at 6:28 p.m. to 8:34 p.m. for a total of 126 minutes -March 27, 2022 at 3:55 p.m. to 4:39 p.m. for a total of 43 minutes and from 6:45 p.m. to 9:46 p.m. for a total of 180 minutes -March 28, 2022 at 12:23 p.m. to 1:04 p.m. for a total of 41 minutes -March 29, 2022 at 7:19 p.m. to 8:03 p.m. for a total of 44 minutes -March 30, 2022 at 4:30 a.m. to 7:39 a.m. for a total of 88 minutes and again from 2:57 p.m. to 4:44 p.m. for a total of 106 minutes -March 31, 2022 at 5:54 a.m. to 9:48 a.m. for a total of 234 minutes; from 10:38 a.m. to 11:21 a.m. for a total of 43 minutes; and from 2:55 p.m.	0 460	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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0 460	Continued From page 3 to 4:30 p.m. for a total of 95 minutes -April 1, 2022 at 4:46 p.m. to 5:42 p.m. for a total of 55 minutes -April 2, 2022 at 4:37 a.m. to 7:19 a.m. for a total of 162 minutes; and from 3:49 p.m. to 4:37 p.m. for a total of 47 minutes -April 4, 2022 at 2:19 p.m. to 4:13 p.m. for a total of 113 minutes -April 7, 2022 from 2:47 p.m. to 4:24 p.m. for a total of 96 minutes and from 7:25 p.m. to 8:09 p.m. for a total of 44 minutes -April 8, 2022 at 3:55 p.m. to 4:43 p.m. for a total of 47 minutes; and from 10:50 p.m. to 11:53 p.m. for a total of 63 minutes -April 10, 2022 at 6:46 a.m. to 7:47 p.m. for a total of 61 minutes; and from 12:06 p.m. to 1:03 p.m. for a total of 57 minutes During an interview on April 12, 2022, at 1:52 p.m., R1's family member (FM)-1 stated they had concerns related to the timing of R1's call light being answered. FM-1 indicated they have witnessed staff disregard R1's call light and also observed R1's call light not be answered for over one hour while being present with R1 at the facility. FM-1 was concered due to R1's requirement of assistance and concerned for R1's health and safety due to the long wait times for the call light to be answered. During an interview on April 12, 2022 at 1:55 p.m., the ED and Director of Nursing (DON) stated they were aware of R1's call light times as FM1 had informed them of extended response times. The ED indicated staff often forget to shut off the pendant when assisting R1 or other residents however could not provide documentation to support that statement. The ED and DON both confirmed call lights should be answered promptly and as soon as staff are able	0 460		

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0 460	Continued From page 4 for all residents and residents should not be waiting over an hour for their call light to be answered by staff. TIME PERIOD FOR CORRECTION: Twenty- one (21) days	0 460		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure the service	01640	Assisted Living Provider 144G.	

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01640	Continued From page 5 plan was implemented as required for 1 of 1 (R1) residents reviewed. R1's service plan indicated the licensee's staff would provide transfer assistance to R1, which was not provided on an instance where it was required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's signed service agreement, dated February 8, 2022, indicated R1 received services for mobility assistance. The service plan indicated R1 required physical assist of one staff member for transfers and bed mobility. R1's master care plan, dated March 23. 2022, indicated R1 had diagnoses which included Parkinson's Disease, osteoporosis, history of falls and urinary tract infections. R1's master care plan further included R1 received assistance with mobility and transfers. R1's careplan indicated R1 was to receive assistance of one staff member for transfers. R1's careplan further indicated electronic monitoring was in place in R1's room with a camera positioned to face R1's bed and recliner. An email sent to the administrator on March 5, 2022, at 7:24 p.m. indicated a concern of transfer assistance not being provided to R1 and included a video of a transfer of R1 by a staff member, unlicensed personnel (ULP)-B.	01640	Minnesota Department of Health is documenting the State Licensing 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	

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01640	Continued From page 6 The video was reviewed on April 12, 2022, at 1:25 p.m. which showed ULP-B pushing R1's wheelchair up to the front of R1's recliner chair. ULP-B directed R1 to stand up from the wheelchair and transfer to the recliner. ULP-B applied the brakes of the wheelchair but did not assist the resident in any capacity during the transfer. ULP-B remained behind the wheechair with her hands on the handles of the wheelchair as R1 makes several attempts to stand up independently and transfer herself from the wheelchair to the recliner. During an interview on April 12, 2022, at 1:52 p.m., R1's family member (FM) indicated they had concerns with care provided at the facility which included transfers of R1. FM stated there was a camera in R1's room and they have seen staff not assist R1 with transfers and "just stand there while she [R1] struggles to get up from the chair." The FM states these concerns have been reported to administrative and nursing staff however the behavior has continued. During an interview on April 12, 2022, at 1:55 p.m., the Director of Nursing (DON) and the Executive Director (ED) stated they were aware of the video and confirmed the transfer was incorrect, stating R1 required stand by or assistance of one staff member with transfers. The DON and ED stated all staff should be following the careplan and service plan and provide transfers in accordance to the care plan and service plan. The DON indicated the incident regarding the transfer of R1 and ULP-B was reviewed and the DON discussed with ULP-B the importance of following the care plan and plans to re-educate all staff in importance of providing correct transfer assistance to prevent further	01640	SUBDIVISION 1-3.	

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01640	Continued From page 7 occurrences. TIME PERIOD FOR CORRECTION: Twenty- one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure medications were administered as prescribed for 1 of 1 (R1) residents reviewed for medication administration. R1 was prescribed an antibiotic on March 26, 2022, and ordered doses of the medication were missed on the next three days. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01760		

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01760	Continued From page 8 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's signed service agreement, dated February 3, 2022, indicated R1 received medication administration and medication management four times daily. R1's master care plan, dated March 23, 2022, indicated R1 had diagnoses which included Parkinson's Disease, osteoporosis, history of falls and urinary tract infections. R1's master care plan further indicated R1 received medication management and administration from facility staff and was assessed as inappropriate to self-administer medications. R1's signed physician orders, dated March 26, 2022, indicated R1 was prescribed Cephalexin (an antibiotic for treatment of a urinary tract infection) 500 milligrams (mg) four times per day (QID) for seven days. An email, dated March 26, 2022, at 6:14 p.m. from R1's family member (FM1), to the administrator, indicated R1 was provided a diagnoses of a urinary tract infection and prescribed Cephalexin 500mg (an antibiotic) four times per day for seven days. The email indicated FM1 administered R1's first dose of the antibiotic at 4:00 p.m. on March 26, 2022, and the medication order was provided to the registered nurse (RN)-A on call who indicated she would ensure the antibiotic was entered into the facility system for R1 to receive the medication. Review of R1's March 2022 Medication	01760		

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01760	Continued From page 9 Administration Record (MAR) indicated the physician order for Cephalexin 500mg QID was added to the MAR on March 26, 2022, with a specified time to provide the second dose on March 27, 2022, at 7:00 a.m. The MAR indicated the medication was not administered on March 27, 2022, as the order did not appear on the MAR for the staff member who was administering medications. The MAR further indicated the Cephalexin 500mg QID order was then updated on March 27, 2022, to be administered at 6:00 a.m., 12:00 p.m., and 6:00 p.m. and 12:00 a.m. The MAR indicated R1 did not receive the 6:00 a.m. Cephalexin doses on March 28, 2022, and March 29, 2022. The MAR did not provide explanation why these doses were missed or not administered. R1's March 2022 progress notes indicated an entry on March 27, 2022 at 1:37 p.m., included a Cephalexin administration error indicating the morning dose on March 27, 2022, was not administered as the medication did not appear on R1's MAR but appeared on a caregiver service plan instead of the MAR. The note indicated the morning dose was missed and the subsequent dose was administered late. The progress note did not reflect any contact or update to R1's family or physician regarding the missed dose. R1's March 2022 progress notes also did not include information regarding the missed Cephalexin doses on March 28 or 29, 2022. No medication error or incident reports were completed regarding the three missed doses of R1's Cephalexin and no information provided regarding whether R1's family or physician were notified of these errors.	01760		

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01760	Continued From page 10 Interview with R1's family member (FM1) on April 12, 2022 at 1:52 p.m. indicated they consistently had concerns related to medication administration at the facility, including medications not being administered as ordered and/or not getting medications on time. FM1 stated they have frequently brought these concerns to the attention of staff and administration. Interview with the Executive Director (ED) and Director of Nursing (DON) on April 13, 2022, at 1:55 p.m. indicated the DON was aware of the medication administration error however failed to complete a medication incident or error report and was unaware of the facility policy and procedure regarding medication errors. The DON indicated R1's medical record was updated including the progress note which identified the medication error upon the error entry on March 26, 2022 and the missed dose. The DON indicated this was a transcription error committed by the on-call nurse who received the order and entered the order into the MAR. The DON indicated he discussed this incident with the nurse however no documentation of this was available in the personnel file or documentation of any follow up regarding the medication error. The DON was unaware of the additional missed doses of the morning Cephalexin on March 27 and 28, 2022. A facility policy, dated August 1, 2021, entitled Medication Management-Administration & Set up included staff will document any reason why medication was not completed as prescribed and document on any follow-up procedures that were provided to meet the resident's needs when the medication was not administered as prescribed or in accordance with their medication management	01760		

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01760	Continued From page 11 plan. An additional policy, dated August 1, 2021, entitled Medication Management - Dosage and Set up included a licensed nurse will ensure all medications are transcribed correctly to the medication administration record (MAR). A further Medication Management-Medication Error Policy, dated August 1, 2021, indicated the facility had a goal of zero medication errors and in the event that an error occurs staff will document, track and resolve the medication error for quality improvement and retrain staff if necessary. The policy included a medication error report form would be completed with each medication error which included the type of error, description of the error, how the error could have been prevented, notifications of the nurse, prescriber and others and actions taken to correct the situation. TIME PERIOD FOR CORRECTION: Twenty- one (21) days	01760		