

STATE LICENSING COMPLIANCE REPORT

Report #: HL36759001C Date Concluded: December 21, 2022

Name, Address, and County of Facility Investigated:
Bestvalue Healthcare Inc

3693 Grovner Road North Oakdale, MN 55128 Washington County

Facility Type: Assisted Living Facility (ALF) Evaluator's Name: Yolanda Dawson, RN

Nurse Evaluator

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.

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER BESTVALUE HEALTHCARE INC 3693 GROVNER ROAD NORTH OAKDALE, MIN 55128 DAY, JD PROVIDER'S PLAN OF CORRECTION FREETR CARD BEFLOENCY MUST BE PRECEDED BY PILL TAKE ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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 compliance 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, faiture to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL36759001C On December 14, 2022, the Minnesota Department of Health conducted a compliance only investigation, there were 4 residents receiving services under the providers, and the following correction orders are issued that were not issued at the time of immediate correction orders. The following correction orders are issued for #HL36759001C tag identification 1640, 0730. BORD TABLE TO AND A TO A		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED						
	36759	B. WING	C 01/01/2023						
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE							
BESTVALUE HEALTHCARE IN	3693 GRC	OVNER ROAD NORTH							

BESTVALUE HEALTHCARE INC OAKDALE, MN 55128							
(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) COMPLETI DATE			
0 000	Continued From page 1	0 000					
			REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).				
0 730 SS=F	144G.43 Subd. 3 Contents of resident record	0 730					
	Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	provided as identification (12) documentation and reviewed the as (13) documentation any resolution; (14) a discharge sustermination notice as when applicable; ar (15) other document chapter and relevant status. This MN Requirements by: Based on interview licensee failed to en	that services have been ed in the service plan; that the resident has received esisted living bill of rights; of complaints received and mmary, including service and related documentation, and estation required under this at to the resident's services or ent is not met as evidenced and record review, the asure the resident's record estion of nursing assessments				
	and Individual Abus	e Prevention Plans (IAPP)s ents (R1, R2, R3, R4, R5) with				
	violation that did no safety but had the president's health or widespread scope (or represent a system)	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	Э :				
	with diagnoses that schizoaffective disc and substance abuse August 1, 2021, ind	facility on January 25, 2021, included schizophrenia, rder, cognitive dysfunction, se. R1's care plan dated icated the resident received g and grooming reminders,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		36759	B. WING		01/0 ²	: 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
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	and behavioral mor	nitoring.				
		a current 90-day assessment. sessment was dated January				
		facility on April 1, 2022, with uded schizoaffective disorder, ssion.				
	R2's record lacked comprehensive ass	a 14-day, 90-day, and sessment.				
	R3 admitted to the facility on July 16, 2021, with diagnoses that included schizophrenia, psychosis, substance abuse and intellectual disability.					
		a 14-day assessment, 90-day omprehensive assessment.				
	with diagnoses that paranoid schizophranxiety, and depressible sheet dated December received services for	facility on September 7, 2022, included diabetes type 2, enia, mild mental disorder, ssion. R4's home care flow ober 2022, indicated R4 or dressing and grooming tion management, and g.				
		a 14-day assessment, 90-day omprehensive assessment.				
	with diagnoses that schizoaffective disc plan dated August services for dressing	facility on November 21, 2020, included diabetes type 2, order, and anxiety. R5's care 1, 2021, indicated R5 received and grooming reminders, ement, glucose monitoring, coring.				

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	PROVIDER OR SUPPLIER	3693 GRC	DRESS, CITY, S	STATE, ZIP CODE D NORTH		
BESTVA	LUE HEALTHCARE IN	IC	E, MN 55128			
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0 730	Continued From pa	ge 4	0 730			
		a 14-day assessment, 90-day omprehensive assessment.				
	12:55p.m., the Lice (LALD) stated she was behind on residents.	on on December 14, 2022, at nsed Assistant Living Director was behind on completing sessment documents. The ad completed care plans and e residents, however, was documents. The LALD stated 90-day assessment and				
	the Registered Nursell 1. Complete an inition date on which the part a contract or on the prospective resident 2. The RN will conducting the assessment and provided will be conducted with services. 4. The RN will provide assessment and provided the comprehensive to more than 14 data 6. Ongoing resident	ted August 1, 2021, indicated se (RN) will: al assessment prior to the prospective resident executes date on which the lit moves in. Buct an in-person evaluation to ent results when the resident ity. admitted according to a plan, the nurse assessment within 72 hours of initiating side the admission visit, nent a comprehensive epare a care plan based on evaluation. In the resident and services are assessment with a reassessment visit to on of the resident and services are assessments must be a reassessments must be a reassessment wisit on of the resident and cannot exceed 90 days				
	TIME PERIOD FOR	R CORRECTION: Seven (7)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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RESTVΔ	LUE HEALTHCARE IN	3693 GR0	OVNER ROAI			
		OAKDAL	E, MN 55128			
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	days					
01640 SS=F	144G.70 Subd. 4 (a implementation and	,	01640			
	that services are fire facility shall finalize (b) The service plant include a signature facility and by the reagreement on the service plan must be resident reassessmant facility must provide about changes to the and how to contact Long-Term Care. (c) The facility must services required be (d) The service plant must be entered into including notice of a when applicable.	calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting services to be provided. The per revised, if needed, based on the needed, based on the information to the resident the facility's fee for services the Office of Ombudsman for the timplement and provide all the current service plan. In and the revised service plan to the resident record, a change in a resident's fees services must be informed of service plan.				
	by: Based on interview licensee failed to in no later than 14 cal	ent is not met as evidenced and record review, the aplement a written service plant endar days after the date provided for three of five R4).				
	•	ed in a level two violation (a				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		36759	B. WING		01/0) 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	-	
BESTVA	LUE HEALTHCARE IN	IC	VNER ROAI E, MN 55128			
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01640	resident's health or widespread scope (or represent a syste or has the potential of the residents). The findings include R2 admitted to the diagnoses that incluanciety, and depresent R2's record lacked R3 admitted to the diagnoses that inclus psychosis, substantial disability. R3's record lacked R4 admitted to the with diagnoses that paranoid schizophroanxiety, and depresent R4's record lacked During a conversation 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent R4's record lacked During a conversation 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent R4's record lacked During a conversation 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent R4's record lacked During a conversation 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that paranoid schizophroanxiety, and depresent 12:55p.m., the Lice (LALD) stated she with diagnoses that the late (LALD) stated she with diagnoses that the late (LALD) stated she with diagnoses that the late (LALD)	potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e: facility on April 1, 2022, with uded schizoaffective disorder, sion. a current service plan. facility on July 16, 2021, with uded schizophrenia, ce abuse and intellectual a current service plan. facility on September 7, 2022, included diabetes type 2, enia, mild mental disorder,	01640			
		an 14 days after the date of				

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Minnesota Department of Health

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BESTVA	LUE HEALTHCARE IN	NC	OVNER ROAL			
			E, MN 55128			
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01640	Continued From pa	age 7	01640			
	home care services already completed.	s are first provided, if not				
	No further informat	ion was provided.				
	TIME PERIOD FOR	R CORRECTION: Seven (7)				

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