Electronically Delivered

April 29, 2024

Licensee
Eastern Home Care Inc
6917 101st Street South
Cottage Grove, MN 55016

RE: Project Number(s) SL39210015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on April 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are 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 statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

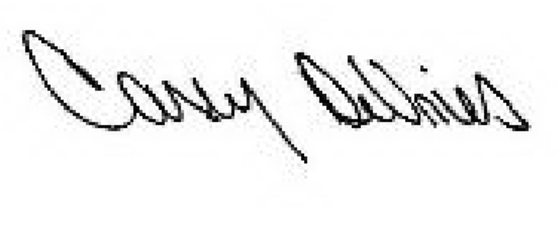
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39210	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39210015-0 On April 8, 2024, through April 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident, the one resident received services under the provisional Assisted Living license. An immediate order for correction was identified on April 9, 2024, issued for SL39210015-0, tag identification 2310. On April 10, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 680		

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0 680	Continued From page 3 a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Plan lacked evidence of the following required content: - quarterly review of missing resident; and - policies and procedure for volunteers. On April 9, 2023, at 12:46 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they were aware of the requirement for quarterly revision of the missing resident policy but they did not revise their document as their resident was non ambulatory. LALD/CNS-D stated they were not aware of the requirement for developing policy and procedures for volunteers. The licensee's Missing Resident policy dated February 4, 2023, indicated the missing resident procedure will be reviewed by the assisted living director and clinical nurse supervisor at least quarterly and changes to the plan will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 810	Continued From page 4	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 5 review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 8, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated 02/04/2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should	0 810		

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0 810	Continued From page 6 follow in case of a fire or similar emergency. During an interview on April 9, 2024, at 12:30 p.m., LALD/CNS-D stated they had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. LALD/CNS-D was unable to provide documentation showing any training offered or training scheduled for a future date for employees on the fire safety and evacuation plan. During an interview on April 9, 2024, at 12:30 p.m., LALD/CNS-D stated they understood the requirements and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 7 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel ((ULP)-A).	01370		

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01370	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on September 29, 2023, to provide direct care to residents. On April 8, 2024, at 11:36 a.m., the surveyor observed ULP-A administer oral and injectable medications to R1. ULP-A's employee record lacked the following competency evaluations: - standby assistance techniques and how to perform them; and - preparation of modified diets as ordered by a licensed health professional. On April 9, 2023, at 8:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they did not train any ULPs on how to perform stand by assist as they did not have resident who requires a standby assist. They also stated they did not train any ULPs on how to prepare modified diet as they did not have residents on modified diets. The Staff Orientation and Education policy dated February 4, 2023, read, "Upon hire and before providing service to residents, all employees attend a general orientation conducted by Eastern Home Care. Those providing direct services will	01370		

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01370	Continued From page 9 complete a competency evaluation as part of the orientation process." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for one of one employee (unlicensed personnel (ULP)-A). 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	01380		

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01380	Continued From page 10 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on September 29, 2023, to provide direct care to residents. On April 8, 2024, at 11:36 a.m., the surveyor observed ULP-A administered oral and injectable medications to R1. ULP-A's employee record lacked the following competency evaluations: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. On April 9, 2023, at 8:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they did not train any ULPs on basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. LALD/CNS -D stated they thought the above-mentioned topic was covered under transfer and positioning topic. The Staff Orientation and Education policy dated February 4, 2023, read, "Upon hire and before providing service to residents, all employees attend a general orientation conducted by Eastern Home Care. Those providing direct services will complete a competency evaluation as part of the orientation process."	01380		

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01380	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system;	01790		

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EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

(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
01790	Continued From page 12 (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for one of one unlicensed personnel ((ULP)-A) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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	01790		

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01790	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on September 29, 2023, to provide direct care to residents. ULP-A's employee record lacked evidence of training and competency in preparing medications for unplanned times away when the licensed nurse is not available. On April 9, 2024, at 10:45 a.m., the surveyor inquired to know the licensee's procedure for leave of absence medication administration. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the ULPs can do medication administration for leave of absence. LALD/CNS-D stated all ULPs were trained on general medication administration procedure but not trained on preparing medication for leave of absence. The licensee's Medication Management Plan for Residents away from Home policy dated February 4, 2023, read, "For unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the Registered Nurse in a timely manner, the Registered Nurse may delegate to an unlicensed personnel (home health aide) to provide the medications based on the following a. The RN has trained the home health aide and determined the home health aide competency to	01790		

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EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

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01790	Continued From page 14 follow procedures for giving medications to residents b. The Registered Nurse has instructed the home health aide to ensure that all appropriate precautions are taken c. The Registered Nurse has developed written procedures/protocols for the home health aide, including special instructions regarding controlled substances (refer also to Protocol for Residents Away from Home), including: i. The type of container(s) to be used for the medications appropriate to the facility's medication system ii. How the container(s) should be labeled iii. Written information about the medications to be provided iv. Documentation requirements: 1. Date medications were provided 2. Who received the medications 3. Who provided the medications to the resident 4. The number of medications that were provided to the resident 5. Any other information" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39210	A. BUILDING: _____ B. WING _____	04/10/2024

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EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

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01880	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's signed Service Plan dated September 24, 2023, indicated R1 received assistance with dressing, grooming, toileting, bathing, medication administration services, and storage/security/risk for diversion (medication). On April 9, 2024, at 8:20 a.m., the surveyor observed the following medications in R1's bedroom in a small white plastic basket on R1's bedside table unlocked and unsecured: -nystatin ointment, 100,000 units (u) per gram (g) topical medication; and -ketoconazole cream 2%. On April 9, 2024, at 12:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated R1 was not able to self-administer medication. LALD/CNS-D stated	01880		

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	39210	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

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01880	Continued From page 16 unlicensed personnels (UPLs) were trained to not leave medication in residents' room and their expectation for medication storage was to store all medication in a locked cabinet. The licensee's Storage/Control of Medication policy dated February 4, 2023, indicated all prescription drugs are securely locked and in substantially constructed compartments manufacturer's directions and only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with hospital bed rails. This resulted in an immediate correction order on April 9, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	02310		

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	39210	A. BUILDING: _____ B. WING _____	04/10/2024

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EASTERN HOME CARE INC	6917 101ST STREET SOUTH COTTAGE GROVE, MN 55016

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02310	Continued From page 17 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, obesity, anemia, major depressive affective disorder, chronic kidney disease, abnormality of the gait. R1's Service Plan dated September 24, 2023, indicated R1 received services for bathing, dining, grooming, medication administration, toileting, and transferring. R1's record included Side-Rail Use Assessment Form, which was completed on November 14, 2023. R1's record lacked a 90-day bed rail assessment which was due to be completed on February 12, 2024. On April 9, 2024, at 8:21 a.m., the surveyor observed R1's hospital bed which had bilateral full (on both sides, upper and lower) hospital bed rails in the lowered position. The surveyor wiggled and pulled on both bed rails which were firmly attached to the bed. On April 9, 2024, at 8:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the resident uses the bilateral upper half of the bed rail for bed mobility. On April 9, 2024, at 9:55 a.m., LALD/CNS-D stated the bed rail assessment is done yearly. LALD/CNS-D stated they were not aware bed rail assessments were required to be completed every 90 days and with change of conditions. LALD/CNS-D stated they would follow the MDH	02310		

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02310	Continued From page 18 guideline and complete the assessment as per the requirement. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." The licensee's Hospital Bed Side Rails Policy dated February 4, 2023, read, "The need for side rail will be reassessed and the side rails inspected as needed, but not less than every 90 days. The ongoing assessment includes a consideration of the following o Inspecting the side rails for any functional	02310		

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02310	Continued From page 19 problems or maintenance issues o Lowering one or more sections of the side rail(s) o Verifying that the mattress is the proper size and prevents entrapment between the mattress and rail o Gaps between the mattress and side rails are reduced o Assuring that the side rails are still installed correctly and that there are no areas for possible entrapment and falls o The side rails are still appropriate to the bed and the resident's needs" No further information provided. TIME PERIOD FOR CORRECTION: Immediate On April 10, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer resident medications according to provider orders for one	02320		

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02320	Continued From page 20 of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's signed Service Plan dated September 24, 2023, indicated R1 received assistance with dressing, grooming, toileting, bathing, medication administration services, and storage/security/risk for diversion (of medication). R1's medication administration record (MAR) for March 2024, indicated R1 took: - Novolog100 unit/ml sliding scale. Blood glucose (BG) less than 200 do not give Novolog. For BG 200 give 5 units (base dose), For BG 201 -250 give additional 2 U, 251 -300 give additional 4 units, 301 -350 give additional 6 U, 351 -400 give additional 8 U, 401 - 450 give additional 10 U and call provider. (Give Novolog before meal). Maximum daily dose 75 units. On April 8, 2024, at 11:36 a.m., the surveyor observed R1's lunchtime medication administration conducted by ULP-A. ULP-A used R1's glucometer (device used to measure BG levels) to check R1's BG which was 233. ULP-A performed hand hygiene, signed into RTask (electronic medical record software) checked the five rights, obtained R1's Novolog FlexPen from the medication cabinet, dialed it to seven units as per the order. ULP-A then cleaned the tip of the	02320		

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02320	Continued From page 21 FlexPen, attached the needle to the FlexPen and was about to administer it into R1's left lower abdomen without priming the FlexPen needle. The surveyor inquired if ULP-A had primed the FlexPen needle. ULP-A stated they were unsure what priming meant. ULP-A stated they dialed it to seven units per the order in RTask. On April 8, 2024, at 11:50 a.m., the surveyor inquired to know if ULP-A was trained on how to give insulin and who trained them. ULP-A stated they were trained on how to give insulin by the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. On April 8, 2024, at 11:56 a.m., the surveyor inquired to know if ULPs were trained on how to prime insulin. LALD/CNS-D stated they were unsure. The surveyor asked LALD/CNS-D to demonstrate their insulin administration procedure. LALD/CNS-D obtained the insulin pen from the medication cabinet and demonstrated administration as follows: put the needle on (without wiping the tip) dial it to the units as per the order and then administer. The surveyor asked if they prime the pen with two units of insulin. LALD/CNS-D stated "we prime it at the beginning of the shift." ULP-A's Employee Training Log, dated with the supervisor verification initials on November 18, 2023, indicated they received medication administration, BG testing, insulin pen, insulin pen priming per manufacture guidelines and administration training. The manufacturer instructions for Novolog FlexPen revised in January 2019, indicated to prime the FlexPens newly attached needle with 2u of insulin.	02320		

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02320	Continued From page 22 The licensee's Medication Administration policy dated February 4, 2023, read, "6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the clients, as appropriate f. Side effects g. resident allergies to medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02320		

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

Type: Full
Date: *04/08/24*
Time: 12:39:29
Report: 1004241089

Food and Beverage Establishment Inspection Report

Location:
Eastern Home Care Inc
6917 101st Street South
Cottage Grove, MN55016
Washington County, 82

Establishment Info:
ID #: 0042204
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPEN PACKAGE OF DELI TURKEY FOUND WITHOUT DATE MARKING. ENSURE ALL TCS PRE-PACKAGED ITEMS ARE CLEARLY DATE MARKED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. DISCUSSED DATE MARKING REQUIREMENTS WITH THE OPERATOR.

Comply By: 04/08/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

SANITIZER TEST KIT/STRIPS COULD NOT BE PRODUCED DURING INSPECTION ON REQUEST. ENSURE SANITIZER TEST STRIPS FOR CHLORINE (BLEACH) ARE ON SITE AND AVAILABLE TO VERIFY MIXING CONCENTRATION FOR THE WET WIPING CLOTH CONTAINER.

Comply By: 04/08/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WIPING CLOTH CONTAINER FOUND WITH A CHLORINE SANITIZER CONCENTRATION OF 0PPM. ENSURE A CONCENTRATION OF 50-100PPM IS MAINTAINED TO LIMIT BACTERIAL

Type: Full
Date: *04/08/24*
Time: 12:39:29
Report: 1004241089
Eastern Home Care Inc

Food and Beverage Establishment Inspection Report

GROWTH ON THE WIPING CLOTH. *DISCUSSED SANITIZER MIXING WITH THE OPERATOR.
Comply By: 04/08/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 176 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Chlorine: = 0PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: TURKEY DELI MEAT
Temperature: 35 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: 35 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY DEE MOSISSA.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-STORAGE ORDER OF RAW FOOD ITEMS
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-TEMPERATURE LOGS
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR,OKECHUKWU, AND WITH THE NURSE EVALUATOR, DEE.

*FLOORS ARE VINYL, WALLS ARE PAINTED DRYWALL AND CEILING IS "ORANGE PEEL"

TEXTURE. COUNTERTOPS ARE SEALED STONE AND CABINETS ARE PAINTED VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004241089 of 04/08/24.

Certified Food Protection Manager OKECHUKWU U. UGWU

Certification Number: FM114233 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

OKECHUKWU UGWU
OPERATOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us