DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 5, 2022

Administrator
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN 55112

RE: Project Number SL27183015

Dear Administrator:

On July 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 9, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 7, 2022

Administrator
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN 55112

RE: Project Number(s) SL27183015

Dear Administrator:

On May 24, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 9, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 9, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 9, 2022, found not corrected at the time of the May 24, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 = $3,000

The details of the violations noted at the time of this follow-up evaluation completed on May 24, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 218-332-51751.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-332-51751 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL27183015-1 On May 23, 2022, through May 24, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 9, 2022. At the time of the survey, there were five residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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 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}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{0 780}	Continued From page 2 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{0 800}	Continued From page 3 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{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	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{0 810}	Continued From page 4 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: No further action required.	{0 810}		
{01760} SS=H	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 observation, interview and record review, the licensee failed to ensure medications were administered per manufacturer's instructions regarding insulin administration for two of two residents (R1, R6); and failed to ensure medications were administered as ordered for one of two residents (R6) with records	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{01760}	Continued From page 5 reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's prescriber orders dated January 17, 2022, included an order for Novolog insulin two units to be administered three times a day before meals. R1's Service Plan dated March 17, 2022, indicated the resident received medication management services to include medication administration. R1's assessment dated May 16, 2022, indicated the resident received services to include medication administration and insulin oversight. On May 24, 2022, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-C using	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{01760}	Continued From page 6	{01760}		

appropriate technique to conduct a blood glucose check on R1 which resulted in a reading of 288 milligrams (mg)/deciliter (dL). ULP-C handed the Novolog insulin pen (a multiple dose pen shaped injector device used for insulin administration) and capped needle to R1. R1 placed the needle on the end of the insulin pen and dialed the pen to two units. ULP-C observed R1 dial the Novolog insulin pen to the prescribed dosage and visually checked the pen to assure the pen was dialed to two units. R1 raised her shirt up and injected the two units of Novolog insulin into her right upper abdomen. R1 was not observed to prime the insulin pen prior to dialing up the prescribed Novolog insulin dose, nor did ULP-C remind R1 to prime the insulin pen prior to administering the two units of Novolog insulin.

R6
R6's diagnoses included diabetes, depression, anxiety and hypertension.

R6's Service Plan dated March 29, 2022, indicated the resident received medication management services to include medication administration. R6's assessment dated May 16, 2022, indicated the resident received services to include medication administration and insulin oversight.

R6's prescriber orders dated March 31, 2022, included an order for Humalog insulin to be administered five units before breakfast; five units before lunch; six units at dinner time; and five units with snacks as needed. Plus, the following Humalog sliding scale (a scale which determines how much insulin should be given based off the blood glucose result) before meals three times a day:
- 200 - 250 mg/dL = 2 units

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{01760}	Continued From page 7 - 251 - 300 mg/dL = 3 units - 301 - 350 mg/dL = 4 units - 351 - 400 mg/dL= 5 units - 401 - 450 mg/dL= 6 units - over 450 mg/dL = 7 units R6's May 1, 2022, through May 23, 2022, medication administration record (MAR) was reviewed and revealed the following: - May 3, at 5:00 p.m., R6's blood glucose (BG) was 240 mg/dL- six units of Humalog insulin was administered [a total of eight units should have been administered] - May 4, at 5:00 p.m., R6's BG was 450 mg/dL - 13 units of Humalog insulin was administered [a total of 12 units should have been administered] - May 9, at 5:00 p.m., R6's BG was 218 mg/dL - six units of Humalog insulin was administered [a total of eight units should have been administered] - May 11, at 5:00 p.m., R6's BG was 450 mg/dL - 13 units of Humalog insulin was administered [a total of 12 units should have been administered] - May 12, at 12:00 p.m., R6's BG was 166 - seven units of Humalog insulin was administered [a total of five units should have been administered] - May 16, at 8:00 a.m., R6's BG was 459 - 11 units of Humalog insulin was administered [a total of 12 units should have been administered] - May 17, at 12:00 p.m., R6's BG was 376 - 11 units of Humalog insulin was administered [a total of ten units should have been administered] - May 17, at 5:00 p.m., R6's BG was 220 - six units of Humalog insulin was administered [a total of eight units should have been administered] - May 18, at 5:00 p.m., R6's BG was 246 - six units of Humalog insulin was administered [a total of eight units should have been administered] - May 19, at 5:00 p.m., R6's BG was 350 - 13 units of Humalog insulin was administered [a total	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{01760}	Continued From page 8 of ten units should have been administered] On May 24, 2022, at 7:39 a.m., registered nurse (RN)-B confirmed the above noted discrepancies and verified the staff were not consistently administering R6's scheduled and sliding scale insulin as prescribed. RN-B stated she had been conducting random monitoring of R6's insulin administration but will now be monitoring his MAR more thoroughly to assure the correct dose of insulin is being administered. On May 24, 2022, at 9:38 a.m., the surveyor observed ULP-C to oversee R6 conduct a blood glucose check which resulted in a reading of 501 mg/dL. ULP-C checked R6's MAR and confirmed with R6 that the dose required for a blood glucose level of 501 was 12 units [5 units as ordered before breakfast plus an additional seven units based off the sliding scale guidance]. ULP-C handed the Humalog insulin pen and capped needle to R6. R6 placed the needle on the end of the insulin pen and dialed the pen to 12 units. ULP-C observed R6 dial the Humalog insulin pen to the prescribed dosage and visually checked the pen to assure the pen was dialed to 12 units. R6 raised his shirt and injected the 12 units of Humalog insulin into his right lower abdomen. R6 was not observed to prime the insulin pen prior to dialing up the prescribed Humalog insulin dose, nor did ULP-C remind R6 to prime the insulin pen prior to administering the 12 units of Humalog insulin. On May 24, 2022, at 10:00 a.m., ULP-C confirmed he had not reminded either R1 or R6 to prime the insulin pen prior to dialing up the prescribed dose. ULP-C was aware insulin pens should be primed with two units prior to dialing up the prescribed insulin dose.	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	R 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
{01760}	Continued From page 9 On May 24, 2022, at 10:05 a.m., RN-B confirmed the ULP should make sure insulin pens were primed with two units prior to dialing up and administering the prescribed dose of insulin. If R1 and R6, did not do this, the ULP should have reminded the resident that this needed to be done. The manufacturer's instructions for the use of Novolog and Humalog insulin pens, dated January 2019, and April 2020 respectively, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage. If this was not completed before each injection too much or too little insulin may be administered. The licensee's undated Insulin Pen policy noted to have the resident prime the pen prior to the resident dialing up the correct dose. Double check the dose before injecting or letting them inject the insulin. No further information was provided.	{01760}		

Electronically Delivered

March 30, 2022

Administrator
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN 55112

RE: Project Number(s) SL27183015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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 licensing 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. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 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: SL#27183015 On, March 7, 2022, through March 9, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 (four) residents, all of whom received services, under the provider's Assisted Living license.	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 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 the potential to affect a large portion or all of the residents). The findings include: On March 7, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-A stated she was the LALD for the facility. LALD-A obtained an assisted living director license on August 16, 2021. On March 8, 2022, at approximately 7:05 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee.	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 110	Continued From page 2 The licensee lacked a policy or procedure related to the LALD role and responsibility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 250	Continued From page 3 access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the assisted living services, understood all of the assisted living provider statutes and rules; and the licensee failed to ensure policies and procedures were developed and/or implemented. 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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 250	Continued From page 4 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 7, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed they were responsible for and participated in the facility's day-to-day operations. LALD-A and RN-B stated they were familiar with the Assisted Living licensing laws and rules. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following] - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81 and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 250	Continued From page 5 - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 250	Continued From page 6 I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorizing agent (LALD-A) on May 18, 2021. The licensee had an Assisted Living license issued on August 1, 2021. The licensee failed to develop and/or implement the following required policies and procedures: - conducting and handling background studies on employees; - orientation to and implementation of the assisted bill of rights; - infection control practices; - medication and treatment management;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 250	Continued From page 7 - delegation of tasks by RN or licensed health professionals; - supervision of RN and licensed health professionals; and - supervision of ULP performing delegated tasks. As a result of this survey, the following orders where issued: 0110, 0250, 0450, 0510, 0650, 0680, 0690, 0730, 0780, 0790, 0800, 0810, 0910, 0930, 0950, 1370, 1440, 1470, 1620, 1650, 1690, 1700, 1760, 1790, 1890, 1930, 1940, 2320, 3090. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 450	Continued From page 8 provided to the resident and a written acknowledgement received for one of one resident (R1) with records reviewed. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee had a current assisted living license. R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's record included a signed copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. On March 8, 2022, at approximately 11:09 a.m., registered nurse (RN)-B verified R1, and all other residents at the facility, had not received the current Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021. On March 9, 2022, at approximately 11:10 a.m.,	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 450	Continued From page 9 licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 480	Continued From page 10 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 included document titled, Food and Beverage Establishment Inspection Report dated March 7, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 510	Continued From page 11	0 510		

nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). This had the potential to affect all four (4) 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 the potential to affect a large portion or all of the residents).

The findings include:

The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated December 7, 2021, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear eye protection in communities with high community transmission levels.

On March 7, 2022, at approximately 3:30 p.m., unlicensed personnel (ULP)-D was observed to assist R3 with transferring and toileting. ULP-D was wearing a medical grade face mask, but no eye protection.

On March 8, 2022, at approximately 7:20 a.m., ULP-D was observed to conduct a blood glucose check on R1. ULP-D was wearing a medical grade face mask, but no eye protection.

On March 8, 2022, at approximately 8:43 a.m., ULP-C was observed to administer R4 his scheduled morning medications. ULP-C was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 510	Continued From page 12 wearing a medical grade face mask, but no eye protection. On March 8, 2022, at approximately 9:30 a.m., ULP-C was observed to transfer R5 with a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-C was wearing a medical grade face mask, but no eye protection. On March 8, 2022, at approximately 11:54 a.m., registered nurse (RN)-B confirmed it was the licensee's expectations that staff follow the current Minnesota Department of Health (MDH) and Center for Disease Control and Prevention (CDC) guidelines with regards to COVID-19 response and PPE usage. RN-B verified their current community transmission level was high and that staff should be wearing a face shield and a medical grade mask when in resident care areas. The licensee's Pandemic Mask and Face Shield Policy, undated, noted staff members are expected to appropriately wear a mask and face shield at all times during their shift. Appropriate use of PPE will prevent and/or minimize the transfer of COVID-19. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 650	Continued From page 13 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included a job description with all the required content for one of two employees (unlicensed personnel (ULP-C)) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 650	Continued From page 14 a minimal impact on the resident and does not affect 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). The findings include: ULP-C was hired on January 10, 2022, to provide direct care services to residents of the facility. On March 8, 2022, at approximately 8:43 a.m., ULP-C was observed to administer R4 his scheduled morning medications. At approximately 9:30 a.m., ULP-C was observed to transfer R5 with a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-C's employee record lacked evidence of a current job description which included the qualifications for the position and identification of staff providing supervision. On March 8, 2022, at approximately 1:18 p.m., licensed assisted living director (LALD)-A and human resource director (HRD)-F confirmed ULP-C's job description did not include all the required content as noted above. The licensee's Job Description policy, undated, did not identify an outline of the items included in a job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 680	Continued From page 15	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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 tenant 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 have a developed written emergency preparedness plan with all the required content. This had the potential to affect all four (4) residents receiving services under the assisted living license.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 680	Continued From page 16 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: During the entrance conference on March 7, 2022, at approximately 1:00 p.m., a request was made to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's emergency preparedness plan provided to the surveyor included an All Hazards Risk Assessment dated June 16, 2021, which identified natural, technological and human events and scored each event based on probability, risk and preparedness. The licensee's emergency preparedness (EP) plan lacked the following facility specific content as required: - development of policies and procedures identified in the facilities risk assessment to include, but not limited to, severe thunderstorm, snow fall, blizzard, ice storm, tornado, flood and temperature extremes; - development of a fire plan; - development of policies and procedures to address: - substance needs for staff and residents during an emergency; - arrangements/contacts to re-establish utility services; - evacuation plan;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 680	Continued From page 17 - a procedure for tracking staff and residents; - shelter in place; - a medical record documentation system to preserve resident information, security and availability; - emergency staffing strategies to include volunteers if applicable ; - contact information and agreements with other facilities to receive residents to maintain the continuity of services to the residents; - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - contact information for federal, state, tribal, and local EP staff; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On March 9, 2022, at approximately 11:40 a.m., LALD-A confirmed they were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD-A verified they had not fully developed and implemented the facility's emergency preparedness plan/program as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 690	Continued From page 18 services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records for one of one resident (R1) for whom they provided services included authentication of documentation with the name and title of the person making the entry with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's Daily Log Notes and Progress Notes (documentation forms for staff to write a narrative note regarding the resident) dated February 1, 2022, through March 7, 2022, were not	0 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 690	Continued From page 19 consistently authenticated with the name and title of the person making the entries. On March 8, 2022, at approximately 11:15 a.m., registered nurse (RN)-B confirmed R1's Daily Log Notes and Progress Notes noted above were not consistently authenticated with the name and title of the person making the entries. RN-B stated all entries should include a signature and title of the staff member making the entry. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding authenticating entries in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 730	Continued From page 20 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 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident record included documentation of the notification to the registered nurse (RN) for one of one resident (R1) who had elevated blood glucose (sugar) results.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 730	Continued From page 21 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's prescriber orders dated January 17, 2022, included an order for blood glucose monitoring four times daily. R1's Diabetic Protocol indicated for a blood sugar result over 300 the nurse should be notified and if over 400 the provider should be notified. R1's Medication Management Plan dated February 14, 2022, indicated R1 needed assistance with blood glucose monitoring four times daily, before meals and at bedtime. On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed using appropriate technique to conduct a blood glucose check on R1 which resulted in a reading of 158 milligrams (mg)/deciliter (dL).	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 730	Continued From page 22 R1's Medication Administration Record (MAR) dated February 21, 2022, through March 7, 2022, indicated R1 received blood glucose monitoring four times daily with results over 300 on the following dates/times: - February 22, 2022, at lunch result of 345; - February 23, 2022, at bedtime result of 303; - February 24, 2022, at breakfast result of 307; - February 25, 2022, at breakfast result of 308; - February 27, 2022, at supper result of 308; - February 28, 2022, at lunch result of 311; - March 2, 2022, at lunch result of 304, at bedtime a result of 315; - March 3, 2022, at supper a result of 326; - March 4, 2022, at lunch a result of 351; - March 5, 2022, at lunch a result of 350; and - March 6, 2022, at lunch a result of 336, at supper a result of 318. On March 8, 2022, at approximately 11:31 a.m., registered nurse (RN)-B stated she has been notified either in person or via the telephone each time R1's blood glucose results have been over 300 as directed on the protocol. RN-B confirmed these notifications were not being documented in R1's record. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding content and documentation requirements for the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 780	Continued From page 23	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the interconnection of smoke alarms in the kitchen and one resident room as required by Minnesota Statutes, 144G.45, Subd. 2. This has 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 780	Continued From page 24 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 8, 2022, between the hours of 10:30 a.m. and 12:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A and the senior program manager (PM)-E. During the home tour, the PM-E tested smoke alarms for the home while survey staff and the LALD-A verified the alarms. Survey staff observed the smoke alarms located inside the bedroom for resident-R3 and in the kitchen on the main floor only sounded local. Survey staff explained to the LALD-A and the PM-E, the requirement was that all smoke alarms must be interconnected, including the smoke alarm in the kitchen and the bedroom of R3, such that when one smoke alarm sounds, all smoke alarms in the home must sound throughout for notification. The findings were evident when smoke alarms inside bedroom R3 and kitchen were tested by the PM-3 and LALD-A, and both alarms sounded local only and not throughout. The PM-E and LALD-A agreed with the findings as they stated that this will be an easy fix. On March 8, 2022, at approximately 12:25 p.m., the PM-E stepped away. On March 8, 2022, at approximately 12:30 p.m., the LALD-A acknowledged the above findings again at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 8, 2022, between the hours of 10:30 a.m. and 12:00 p.m., survey staff toured the home with the licensed assisted living director	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 790	Continued From page 26 (LALD)-A and the senior program manager (PM)-E. During the home tour, survey staff observed one portable fire extinguisher located on the main floor and one located in the basement, and both were tagged with an annual service date of September 2021, but both lacked records to show the monthly inspections. These findings were verified with the LALD-A and PM-E as the LALD-A commented that the information was good to know and the PM-E asked if quick monthly checks can be performed by employees. Survey staff explained that the portable fire extinguishers may be performed by employees after they the annual serviced by the qualified vendor. On March 8, 2022, at approximately 12:25 p.m., the PM-E stepped away. On March 8, 2022, at approximately 12:30 p.m., the LALD-A acknowledged the above findings again during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 800	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 8, 2022, between the hours of 10:30 a.m. and 12:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A and the senior program manager (PM)-E. 90-MINUTE FIRE-RATED DOOR -At approximately 11:00 a.m., survey staff observed that the home was one of two townhouse construction separated by what appeared to be a fire-rated wall construction, consisting of a 90-minute fire door (labeled) with another door on the other side. Further observations were made by survey staff that the door hardware on the 90-minute fire door was tampered with since the door latch was missing and the hole was covered with an approximate 1.5-inch size cover cap, affecting the integrity of the fire separation between the two homes. Furthermore, the 90-minute fire-rated door did not self-close to keep the integrity of the fire separation and survey staff also observed the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 800	Continued From page 28 door to be in the opened position. The LALD-A and the PM-E explained that the wall and door separation between the two homes was constructed back approximately in 2010 and city permits were obtained, and both homes were licensed separately as assisted living facilities. - At approximately 11:30 a.m., survey staff toured the mechanical room in the lower level. Survey staff observed that the building water service served the home's water supply and the fire sprinkler system, and the sprinkler system riser lacked a tag of an annual inspection and testing of the sprinkler system. The LALD-A explained that she was not aware that was a fire sprinkler system for the home and stated that the system as far as she was aware considered the system to be nonfunctional as the system has not been maintained to her knowledge. FRONT ENTRY DOOR The front entry door had a keycode door lock to lock the front door from the inside that restricted the residents from exiting the home if used. When survey staff asked about the keycode lock, the PM-E explained that they previously had a resident that wondered, but no longer, and at that time, they installed the keycode lock to restrict resident elopement. The LALD-A and the PM-E clarified that at that time, all employees had the code to exit and had proper approval through all residents and their families to use the keycode lock. Survey staff asked if this lock had been installed before or after the last visit by the local fire inspector. The PM-E stated that the keycode lock was installed after their last visit and was currently not being used and they intended on removing it. Survey staff explained that this keycode lock posed concerns of restricting exiting for residents during an emergency and needed to	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 800	Continued From page 29 be reviewed with the local fire marshal for compliance with local codes. BEDROOM in LOWER LEVEL Although the bedroom in the lower level was currently not occupied but during the tour survey staff observed that the air return grille was heavily layered with thick dust, and the windowsill and windows were dusty, and needed to be cleaned. On March 8, 2022, at approximately 12:25 p.m., the PM-E stepped away. On March 8, 2022, at approximately 12:30 p.m., the LALD-A acknowledged the above findings during the exit interview. She stated that they will likely replace the 90-minute fire-rated door with a solid wall. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 810	Continued From page 30 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 interview, observation, and record review, the licensee failed to provide the full required content of documentation on the fire safety and evacuation plans, as well as failed to provide the required minimum number of evacuation drills, and the minimum required training of staff on evacuation. This has the potential to directly affect the health and safety of all residents, and staff. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 810	Continued From page 31 of the residents). The findings include: On March 8, 2022, between the hours of 10:30 a.m. and 12:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A and the senior program manager (PM)-E. On March 8, 2022, at approximately 12:00 p.m., survey staff reviewed the fire safety and evacuation plan documentation, training policies and procedures, and related drill records. FIRE SAFETY AND EVACUATION PLAN: -The documentation lacked site-specific procedures for employee fire protection details necessary for the resident evacuation including written instructions for addressing any unique resident situation during evacuation including for residents who are wheelchair-bound, blind and/or deaf, or needing assistance during an evacuation. During the tour, survey staff observed multiple residents who was wheelchair-bound and/or needing assistance during an evacuation. -The documentation lacked specific fire protection procedures for residents. TRAINING -The policy documentation lacked the minimum required frequency of employee training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter. The LALD-A acknowledged the finding as she stated that they provided training upon hire and annually. -The policy documentation lacked the minimum required frequency of resident training on fire safety and evacuation plan. FIRE DRILLS AND EVACUATION	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 810	Continued From page 32 The policy documentation lacked the minimum required frequency of employee fire and evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month. Record review showed insufficient numbers of fire and evacuation drills were performed. Documented records showed the last evacuation drills performed twice a year dated, 10/4/2021, at 3:30 a.m. and 4/7/2021, at 2:00 p.m. On March 8, 2022, at approximately 12:25 p.m., the PM-E stepped away. On March 8, 2022, at approximately 12:30 p.m. the LALD-A acknowledged the above findings at the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 910 SS=A	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 910	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's service plan dated March 2, 2022, indicated the resident received services which included medication administration, bathing, grooming, and dressing. R1's [name of facility] Assisted Living Contract and Placement Agreement signed March 2, 2022, lacked the license number of the facility. This portion of the assisted living contract was blank. On March 8, 2022, at approximately 11:01 a.m., registered nurse (RN)-B confirmed R1's assisted	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 910	Continued From page 34 living contract did not include the license number of the facility. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding content of the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 930	Continued From page 35 by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. This affected all four (4) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's service plan dated March 2, 2022, indicated the resident received services which included medication administration, bathing, grooming, and dressing. R1's [name of facility] Assisted Living Contract and Placement Agreement signed March 2, 2022, lacked the following content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 930	Continued From page 36 transfer. On March 8, 2022, at approximately 11:04 a.m., registered nurse (RN)-B confirmed they used the same assisted living contract for all residents and the licensee's assisted living contract lacked the required content as noted above. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding content of the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 950	Continued From page 37 attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
0 950	Continued From page 38 behavior that impairs daily functioning). R1's service plan dated March 2, 2022, indicated the resident received services which included medication administration, bathing, grooming, and dressing. R1's [name of facility] Assisted Living Contract and Placement Agreement signed March 2, 2022, included the Right to Designate a Representative form which was left blank. On March 8, 2022, at approximately 11:06 a.m., registered nurse (RN)-B confirmed R1 had not been provided the opportunity to identify a designated representative. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding designated representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=D	144G.61 Subd. 2 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; (3) basic infection control, including blood-borne pathogens;	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01370	Continued From page 39 (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 was completed for one of one unlicensed personnel (ULP-C) to include all required content with records reviewed. This practice resulted in a level two violation (a	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01370	Continued From page 40 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). The findings include: ULP-C was hired on January 10, 2022, to provide direct care services to residents of the facility. ULP's employee record lacked documentation of training and competency evaluations for the following topics: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aides; - dressing and assisting with toileting; and - understanding appropriate boundaries between staff and residents and the resident's family On March 8, 2022, at approximately 8:43 a.m., ULP-C was observed to administer R4 his scheduled morning medications. At approximately 9:30 a.m., ULP-C was observed to transfer R5 with a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). On March 8, 2022, at approximately 2:47 p.m., licensed assisted living director (LALD)-A and human resource director (HRD)-F confirmed ULP-C's employee record lacked documentation of training and/or competency evaluations for the above topics, as required. The licensee's Staff Training policy dated May 25, 2021, indicated ULP providing assisted living	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01370	Continued From page 41 services must have successfully completed a training and competency evaluation appropriate to the services provided by the facility or demonstrated competency by satisfactorily completing a written or oral test on the tasks the ULP will perform in the presence of nursing staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01440	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-C with records reviewed. 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). The findings include: ULP-C was hired on January 10, 2022, to provide direct care services to residents of the facility. On March 8, 2022, at approximately 8:43 a.m., ULP-C was observed to administer R4's scheduled morning medications. At approximately 9:30 a.m., ULP-C was observed to transfer R5 from her bed to the wheelchair using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-C's employee record lacked documentation of a RN supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On March 9, 2022, at approximately 8:55 a.m., RN-B confirmed ULP-C's 30-day supervision of delegated tasks had not been completed as	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01440	Continued From page 43 required. On March 9, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding completing a 30-day supervision of ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01470	Continued From page 44 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content was completed for two of two employees (registered nurse (RN-B) and unlicensed personnel (ULP-C)) with records reviewed.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01470	Continued From page 45 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: RN-B RN-B started employment on April 9, 2014, under the comprehensive home care license and began providing assisted living services and supervision on August 1, 2021. ULP-C ULP-C was hired on January 10, 2022, to provide direct care services to residents at the facility. On March 8, 2022, at approximately 8:43 a.m., ULP-C was observed to administer R4 his scheduled morning medications. At approximately 9:30 a.m., ULP-C was observed to transfer R5 with a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). RN-B and ULP-C's employee records lacked the following required orientation content: - an overview of the 144G statutes; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 8, 2022, at approximately 12:32 p.m., human resource director (HRD)-F confirmed RN-B and ULP-C had not completed the above	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01470	Continued From page 46 noted orientation as required. The licensee's Staff Training policy dated May 25, 2021, noted all staff would be orientated to the services offered by the licensee as identified in the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01620	Continued From page 47 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for one of one resident (R1) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). R1's service plan dated March 2, 2022, indicated the resident received services which included medication administration, bathing, grooming, and dressing. On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed to administer R1 her scheduled morning	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01620	Continued From page 48 medications and conduct a blood glucose check which resulted in a reading of 158 milligrams (mg)/deciliter (dL). R1's record included Supervisory Visit Notes dated October 21, 2021, December 16, 2021, and February 28, 2022. These assessments indicated all "home care" services were being performed adequately and that the resident's mental/physical health was stable. These assessments did not include all the elements on the uniform assessment tool as required. On March 8, 2022, at approximately 10:39 a.m., registered nurse (RN)-B confirmed R1's ongoing assessments did not include a review of all the required elements. RN-B verified they had only implemented the uniform assessment tool for conducting resident assessments on the newly admitted residents. The licensee's Resident Assessment policy dated January 27, 2021, indicated every 90 days, nursing would visit each resident to complete a 90-day assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 49 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) with records reviewed. This had the potential to affect all four (4) residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 50 the residents). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning). On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed to administer R1 her scheduled morning medications and conduct a blood glucose check. R1's service plan dated March 2, 2022, did not include the method of monitoring assessments of the resident. On March 8, 2022, at approximately 10:47 a.m., registered nurse (RN)-B confirmed R1's service plan was incomplete and did not include above noted content. RN-B stated this was a template service plan that was used for all residents. The licensee's Service Plan Implementation and Revision policy, undated, noted the service plan would include the schedule and method of monitoring reviews or assessments of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01690	Continued From page 51	01690		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01690	Continued From page 52 licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 7, 2022, at approximately 12:10 p.m., the registered nurse (RN)-B and licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to all four (4) residents at the facility. On March 7, 2022, at approximately 1:00 p.m., the licensee's assisted living licensing policies and procedures were requested from LALD-A and RN-B. The policies and procedures provided did not include the medication management services policy regarding verifying that prescription drugs are administered as prescribed. On March 9, 2022, at approximately 9:43 a.m., LALD-A and RN-B confirmed the above noted policy for medication management services had not been developed. No further information was provided.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01690	Continued From page 53 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01700	Continued From page 54	01700		

review, the licensee failed to ensure medication management assessments completed by the registered nurse (RN) to determine what medication management services would be provided included all required content for one of one resident (R1) with records reviewed.
This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
During the entrance conference on March 7, 2022, at approximately 12:10 p.m., the registered nurse (RN)-B and licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to all four (4) residents at the facility.
R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning).
R1's Medication Management Plan and Service Plan dated February 14, 2022, and March 2, 2022, respectively, indicated the resident received medication management services.
R1's prescriber orders dated January 17, 2022, included one antidepressant, one antihypertensive, one oral anti-diabetic medication, one medication to lower cholesterol, one anti-psychotic, two inhalers, two insulins, one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01700	Continued From page 55 laxative and one vitamin. On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed to administer R1 her scheduled morning medications. R1's record lacked evidence the RN conducted a face-to-face review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the residents' record lacked to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On March 8, 2022, at approximately 9:44 a.m., RN-B confirmed a face-to-face medication management assessment had not been completed to include all the required content noted above for R1. The licensee's Medication Management policy, undated, noted for each resident requesting medication management services, the director of nursing (DON) would conduct an assessment to determine what medication management services would be provided and how these services would be provided. The DON assessment would be conducted face-to-face with the resident and include a review of the indications, side effects, contraindications, allergic or adverse reactions and actions to address any issues. The DON will identify interventions needed to prevent diversion of medications by the resident or other in the home that may have access to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01760	Continued From page 56	01760		
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 observation, interview and record review, the licensee failed to ensure medications were administered via manufacturer's instructions regarding insulin and inhaler administration for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01760	Continued From page 57	01760		

pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning).

R1's Medication Management Plan and Service Plan dated February 14, 2022, and March 2, 2022, respectively, indicated the resident received medication management services to include medication administration and assistance with injecting insulin.

R1's prescriber orders dated January 17, 2022, included an order for Novolog insulin 2 units to be administered three times a day before meals and Breo Ellipta (corticosteroid inhaler)100/25 micrograms (mcg) one puff to be inhaled daily.

On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed using appropriate technique to conduct a blood glucose check on R1 which resulted in a reading of 158 milligrams (mg)/deciliter (dL). ULP-D handed the Novolog insulin pen (a multiple dose pen shaped injector device used for insulin administration) and the capped needle to R1. R1 placed the needle on the end of the insulin pen and dialed the pen to 2 (two) units. ULP-D observed R1 dial the Novolog insulin pen to the prescribed dosage and visually checked the pen to assure the pen was dialed to 2 units. R1 immediately raised her shirt up and injected the 2 units of Novolog insulin into her upper abdomen. R1 was not observed to prime the insulin pen prior to dialing up the prescribed Novolog insulin dose, nor did ULP-D remind R1 to prime the insulin pen prior to administering the 2 units of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01760	Continued From page 58 Novolog insulin. On March 8, 2022, at approximately 7:25 a.m., R1 was seated at the dining room table. ULP-D was observed to conduct a medication pass for R1 which included administration of the Breo Ellipta 100/25 mcg inhaler. ULP-D activated the Breo Ellipta inhaler; handed the inhaler to R1; R1 released one puff of the inhaler into her mouth and took a long, fast breath in; R1 handed the inhaler back to ULP-D. ULP-D proceeded to complete the medication pass and handed R1 the rest of her scheduled morning medications. ULP-D did not instruct R1 to rinse her mouth out after the administration of the Breo Ellipta inhaler. On March 8, 2022, at approximately 7:36 a.m., ULP-D confirmed she had not reminded R1 to prime the insulin pen prior to dialing up the prescribed dose. ULP-D stated she should have directed R1 to prime the Novolog insulin pen with two units prior to dialing up the prescribed two units to be administered. ULP-D also confirmed she had not instructed R1 to rinse her mouth out following the administration of the Breo Ellipta inhaler. ULP-D was unaware this should be done. On March 8, 2022, at approximately 10:32 a.m., registered nurse (RN)-B confirmed the ULP should make sure insulin pens were primed with two units prior to dialing up and administering the prescribed dose of insulin. If R1, did not do this, the ULP should have reminded the resident that this needed to be done. RN-B also confirmed following administration of the Breo Ellipta inhaler the ULP should have had R1 rinse her mouth out with water. The manufacturer's instructions for the use of Novolog insulin pens, dated January 2019,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01760	Continued From page 59 directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage. If this was not completed before each injection too much or too little insulin may be administered. The manufacturer's instructions for use of the Breo Ellipta inhaler, dated March 2020, indicated the resident should rinse their mouth with water after use and spit the water out. Do not swallow the water. The licensee's Insulin Pen policy, undated, did not include verbiage regarding priming the insulin pen prior to dialing up and administering the prescribed insulin dosage. The licensee's Medication Administration Procedure, undated, indicated following the administration of a steroid inhaler the resident should rinse their mouth out. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 60 (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; (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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 61 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) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 7, 2022, at approximately 12:10 p.m., registered nurse (RN)-B confirmed the licensee provided medication management services to all four (4) residents at the facility. RN-B confirmed the ULP would prepare and send medications with residents for unplanned times away. The licensee's Medication Management for Residents Away From Home policy, undated,	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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 62 indicated for planned time away from the director of nursing (DON) would setup all medications for the resident to utilize when away from home. When a resident had unplanned time away from home, direct care staff would setup the resident's medications for the resident to utilize while away from home. The licensee's policy lacked the written procedure to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting 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; and - how the ULP 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. On March 9, 2022, at approximately 10:32 a.m., RN-B and licensed assisted living director (LALD)-A confirmed the licensee's Medication Management for Residents Away From Home Policy did not include the above noted content as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01890	Continued From page 63	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R1) and failed to monitor for expired stock medications. 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: On March 7, 2022, at approximately 1:10 a.m., a tour of the facility was conducted with registered nurse (RN)-B, including a review of the medication closet. The following was observed, and confirmed with RN-B: ORIGINAL PRESCRIPTION LABEL R1's Breo Ellipta (corticosteroid inhaler) 100/25	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01890	Continued From page 64 micrograms (mcg) and Incruse Ellipta 62.5 milligrams (mg) inhalers lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which they had been issued. TIME SENSATIVE MEDICATIONS R1's opened Novolog 100 units/milliliter (ml) and Basaglar 100 units/ml insulin pens (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pens had been opened and when the pens would expire. R1's Breo Ellipta 100/25 mcg and Incruse Ellipta 62.5 mg inhalers did not have a label which indicated the date the inhalers had been removed from their foil pouches and when they would expire. EXPIRED MEDICATION In the stock medication bin, the following medications were found to be expired: - one bottle of liquid antacid expired March 2021; - one bottle of docusate sodium 100 milligram (mg) (stool softener) expired September 2020; - one bottle of ibuprofen 200 mg (mild pain reliever) expired August 2020; and - one bottle of diphenhydramine HCL 25 mg (antihistamine) expired July 2018. On March 7, 2022, directly following the above observation RN-B confirmed all medications should have an original prescription label and insulin pens should be labeled with the date they were opened and then discarded after 28 days. RN-B stated all expired medications should be discarded.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01890	Continued From page 65 The manufacturer's instructions for Novolog, dated June 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Basaglar insulin pens dated September 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for the use of the Breo Ellipta inhaler dated March 2020, directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. The tray opened and discard dates should be written on the inhaler label. The manufacturer's instructions for the use of the Incruse Ellipta inhaler dated June 2019, directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. The date opened should be written on the label of the inhaler. The licensee's Provision of Medication Management Services policy dated April 4, 2016 (dated prior to August 1, 2021, assisted living licensure) noted expired medications would be removed from the active set of medications by the RN, Program Manager or direct care staff. All medications are kept secured until they are destroyed, which occurs monthly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01930	Continued From page 66	01930		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. 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	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01930	Continued From page 67 of the residents). The findings include: During the entrance conference on March 7, 2022, at approximately 12:20 p.m., registered nurse (RN)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. On March 7, 2022, at approximately 1:00 p.m., the licensee's assisted living licensing policies and procedures were requested from LALD-A and RN-B. The policies and procedures provided did not include treatment and therapy policies to address the following: - providing the treatment or therapy - documenting treatment or therapy activities - monitoring and evaluating the treatment or therapy, and - communicating with the prescriber On March 9, 2022, at approximately 10:04 a.m., LALD-A and RN-B confirmed the above noted treatment and therapy management services policies and procedures had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01940	Continued From page 68 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) with records reviewed. 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01940	Continued From page 69	01940		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

During the entrance conference on March 7, 2022, at approximately 12:20 p.m., registered nurse (RN)-B and licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed.

R1's diagnoses included diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), and schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning).

R1's prescriber orders dated January 17, 2022, included an order for blood glucose monitoring four times daily.

R1's Medication Management Plan dated February 14, 2022, indicated R1 needed assistance with blood glucose monitoring four times daily, before meals and at bedtime. R1's Medication Administration Record (MAR) dated February 1, 2022, through March 7, 2022, indicated R1 received blood glucose monitoring four times daily.

On March 8, 2022, at approximately 7:20 a.m., unlicensed personnel (ULP)-D was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
01940	Continued From page 70 using appropriate technique to conduct a blood glucose check on R1 which resulted in a reading of 158 milligrams (mg)/deciliter (dL). R1's record lacked a complete treatment plan as R1's service plan dated May 28, 2019, lacked a written statement of the treatment services the resident received to include blood glucose monitoring. On March 8, 2022, at approximately 11:42 a.m., RN-B confirmed R1's treatment plan was incomplete as R1's service plan did not include a written statement of the treatment services R1 received as required. On March 9, 2022, at approximately 11:10 a.m., LALD-A confirmed the licensee did not have a policy regarding treatment plan content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 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 provide care and	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 71 services according to acceptable health care medical or nursing standards for medication set up by unlicensed personnel (ULP) for one of two residents (R4) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C completed medication setup for later administration for R4. R4's diagnoses included atrial fibrillation (irregular, often fast heartrate) and legally blind. R4's service plan dated September 13, 2021, indicated the resident received services which included medication administration. R4's prescriber orders included one antibiotic, one medication to treat heartburn, one diuretic, one antihypertensive, one medication to treat congestion, one medication to treat urinary retention, one cholesterol lowering medication, one medication to treat nerve pain, one medication to help maintain the normal flora in the gut, one antidepressant, one laxative, one blood thinner, one mild pain reliever and three vitamin/mineral supplements. On March 8, 2022, at approximately 8:10 a.m., ULP-C was observed to review R4's medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 72	02320		

administration record (MAR) and blister pack medication card (a transparent molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) and setup the following medications placing them in a medication cup: omeprazole 20 milligrams (mg) (medication to treat heartburn); cephalexine 500 mg (antibiotic); ferrous sulfate 325 mg (iron supplement); potassium ER 10 milliequivalents (mEq); tamsulosin 0.8 mg (medication to treat urinary retention); vitamin D3 1000 units; Lasix 20 mg (diuretic); metoprolol ER 150 mg (antihypertensive); mucus relief ER 600 mg (for congestion); Probiotic 250 mg (helps maintain the normal flora of the gut); gabapentin 300 mg (to treat nerve pain); and Tylenol 1000 mg (mild pain reliever). ULP-C then covered the medication cup with a piece of a paper napkin and placed the covered medication cup back into R4's medication bin. ULP-C placed the bin in the locked medication closet. ULP-C proceeded to make breakfast for R4 which included oatmeal, eggs, and toast. At approximately 8:43 a.m., ULP-C retrieved R4's medication cup from the locked medication cupboard; entered R4's room and administered R4's scheduled morning medications which he had setup earlier.

On March 8, 2022, at approximately 10:37 a.m., registered nurse (RN)-B stated medications should be administered immediately after setting them up. ULP should not be setting up medications for later administration.

The licensee's Preparing and Giving Medications policy, undated, noted after completing the five rights with comparing the medication card and MAR, pop the meds out of the bubble pack and into a medication cup. Return the med cards to the locked cabinet and give the medications to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 73 the client with a glass of water. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 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, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27183	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2517 COUNTY ROAD I MOUNDS VIEW, MN 55112

(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
03090	Continued From page 74 all four (4) residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 7, 2022, at approximately 12:05 p.m., this surveyor entered the facility. There was no signage posted in the entryway of the facility regarding electronic monitoring devices. On March 7, 2022, at approximately 1:40 p.m., the licensed assisted living director (LALD)-A stated the licensee currently did not have any video cameras in or around the facility. LALD-A confirmed the licensee did not have signage posted in the entryway regarding electronic monitoring as required. On March 9, 2022, at approximately 11:10 a.m., LALD-A confirmed the licensee did not have a policy regarding signage for electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *03/07/22*
Time: 13:50:58
Report: 7958221048

Food and Beverage Establishment Inspection Report

Location:
Scenic Hills Alternative Care
2517 County Road I
Mounds View, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0038731
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634327228
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.

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A SMALL DIAMETER PROBE THERMOMETER TO MEASURE COOK TEMPERATURES OF THIN FOODS SUCH AS BURGERS, CHICKEN TENDERS, ETC. OBTAIN THERMOMETER WITH THIN DIAMETER PROBE AS REQ. BY ABOVE RULE.

Comply By: 03/07/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A TEMPERATURE MEASURING DEVICE, AS DESCRIBED IN ABOVE RULE, TO MEASURE UTENSIL SURFACE TEMPERATURE INSIDE THE HIGH TEMPERATURE DISH MACHINE. OBTAIN A DEVICE FOR DETERMINING UTENSIL SURFACE TEMP.

Comply By: 03/07/22

Surface and Equipment Sanitizers

Ambient air temperature: = at 38 Degrees Fahrenheit
Location: Household refrigerator
Violation Issued: No

Ambient air temperature: = at -9 Degrees Fahrenheit
Location: Freezer portion of household refrigerator
Violation Issued: No

Utensils surface temperatu: = at 160+ Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Shredded cheese
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY GEORGE WAHL IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION EVALUATION. DISCUSSED WITH CRYSTAL HOWARD, CFPM OF THE FACILITY, THE FOOD SERVICE PROVIDED TO RESIDENTS OF THIS FACILITY. MAXIMUM NUMBER OF RESIDENTS THAT ARE EVER AT THIS FACILITY AT THE SAME TIME IS FIVE. SHE STATED THAT ALL MEALS ARE PROVIDED FOR SAME-DAY SERVICE AND CONFIRMED THAT MEALS ARE NOT EVER PREPARED IN ADVANCE & THEN FROZEN OR HELD COLD FOR SERVICE AT A LATER DATE.

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE DISH MACHINE WAS DETERMINED USING A MULTI STRIP THERMAL LABEL TO BE AT LEAST 160.0 DEGREES F., WHICH IS THE MINIMUM UTENSIL SURFACE TEMPERATURE REQUIRED BY THE MINNESOTA FOOD CODE.

AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

KITCHEN IS A TRADITIONAL HOUSEHOLD KITCHEN, FLOORS IS VINYL TILE, WALLS ARE A COMBINATION OF CERAMIC TILE AND PAINTED SURFACES, CEILING HAS A TEXTURED PAINTED FINISH. ALL FINISHED SURFACES ARE IN VERY GOOD CONDITION AND ARE CLEAN.

DISCUSSED WITH MS. HOWARD ALL ORDERS DOCUMENTED IN THIS REPORT. ALSO DISCUSSED HAND WASHING, GLOVE USAGE/ELIMINATION OF BARE HAND CONTACT WITH FOODS, SANITIZING.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT: TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & TO EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK

OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT THE FACILITY.

**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 7958221048 of 03/07/22.

Certified Food Protection Manager: Crystal Howard

Certification Number: FM64664 Expires: 09/30/24

Inspection report reviewed with person in charge and emailed.

Signed:_____

Crystal Howard
Director of Programs/CFPM

Signed:_____

George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us