

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 16, 2023

Licensee Alternative Senior Care, Inc. 418 10th Street South Sauk Centre, MN 56378

RE: Project Number(s) SL30189008

Dear Licensee:

On June 6, 2023, the Minnesota Department of Health completed a follow-up survey of your agency to determine if orders from the April 6, 2023, survey were corrected. This follow-up survey verified that the agency is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

elly thorson

Kelly Thorson, Supervisor State Evaluation Team Email: kelly.thorson@state.mn.us Telephone: 320-223-7336 Fax: 651-281-9796

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 27, 2023

Licensee Alternative Senior Care, Inc 418 10th Street South Sauk Centre, MN 56378

RE: Project Number(s) SL30189008

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. §626.5572 and/or Minn. Stat. Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144A.474, Subd. 11(a), fines and enforcement actions may be imposed based on the level and scope of the violations and may be 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 § 144A.475 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subd. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual

Alternative Senior Care, Inc April 27, 2023 Page 2

assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(6), 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.

In accordance with Minn. Stat. § 144A.474,Subd. 11, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey at your agency**.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, 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 MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144A.44 Subd. 1(14), 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit Health Regulation Division Alternative Senior Care, Inc April 27, 2023 Page 3

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor State Evaluation Team Email: casey.devries@state.mn.us Telephone: 651-201-5917 Fax: 651-281-9796

PMB

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		H30189	B. WING		04/06/2023
	PROVIDER OR SUPPLIER	418 10TI	DDRESS, CITY, H STREET S ENTRE, MN	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL
0 000	Initial Comments		0 000		
0 810 SS=F	CORRECTION OR In accordance with 144A.43 to 144A.44 been issued pursua Determination of with corrected requires of requirements provide indicated below. With contains several ite of the items will be compliance. INITIAL COMMENT SL30189008 On April 4, 2023, the Minnesota Departments provider and the following the following the following provider and the following t	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute ems, failure to comply with any considered lack of TS: Trough April 6, 2023, the hent of Health, visited the sive home care licensed llowing correction orders were of the survey, there were 59 rvices under the ense.		Minnesota Department of Health documenting the State Licensin Correction Orders using federal Tag numbers have been assign Minnesota State Statutes for Ho Providers. The assigned tag nu appears in the far left column er Prefix Tag." The state Statute nu the corresponding text of the sta out of compliance is listed in the "Summary Statement of Deficie column. This column also includ findings which are in violation of requirement after the statement Minnesota requirement is not m evidenced by." Following the su findings is the Time Period for C PLEASE DISREGARD THE HE THE FOURTH COLUMN WHIC STATES,"PROVIDER'S PLAN C CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONL WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES. THE LETTER IN THE LEFT CC USED FOR TRACKING PURPO REFLECTS THE SCOPE AND ISSUED PURSUANT TO 144A. SUBDIVISION 11 (b)(1)(2).	g software. ed to ome Care imber ntitled "ID umber and ate Statute incies" des the f the state f, "This et as rveyors' Correction. ADING OF CH DF S TO Y. THIS E. TO TION FOR STATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		H30189	B. WING		04/	06/2023
IAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
		418 10TH	STREET S			
ALIERN	ATIVE SENIOR CARE	, INC SAUK CE	NTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 810	Continued From pa	ge 1	0 810			
	implement an indivi each vulnerable mi care services are p provider. The plan s review or assessme susceptibility to abu including other vuln person's risk of abu or minors; and state measures to be tak abuse to that perso or minors. For purp	e provider must develop and idual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized ent of the person's use by another individual, terable adults or minors; the using other vulnerable adults ements of the specific en to minimize the risk of n and other vulnerable adults oses of the abuse prevention e includes self-abuse.				
	by: Based on interview licensee failed to en prevention plan was	ent is not met as evidenced and record review, the nsure an individual abuse s developed to include the r four of four clients (C2, C4,				
	violation that did no safety but had the p client's health or sa cause serious injur was issued at a wid problems are perva failure that has affe	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has the potential to n or all of the clients).				
	The findings include	e:				
	individualized abus the following require	3's records lacked an e prevention plan to include ed content: eview or assessment of the				

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	D.	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		H30189	B. WING		04/06/2023
NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY,	STATE, ZIP CODE	
ALTERN	ATIVE SENIOR CARE	INC .	8 10TH STREET S AUK CENTRE, MN	56378	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
0 810	Continued From pa	age 2	0 810		
		ility to abuse by another g other vulnerable adults	or		
	C2 C2's diagnoses inc diabetes, and chro	luded muscle weakness nic pain.	,		
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated Jul received services incluc ement with medication s ousekeeping.	ly 23, ling		
	2022, indicated C2 and time, and had need for assistance safe and clean, wa pain, and had aggr especially to wife, a be taken to minimiz and other vulnerab assessment lacked to abuse by another	Assessment, dated March was oriented to person, vulnerabilities including of e with keeping his enviro s at risk for falls, had chi ressive behavior toward of and noted specific measure ze the risk of abuse to hi le adults; however, the d a review of C2's suscept er individual, including other minors, and susceptibi	place current nment ronic others, ures to mself otibility ner		
		luded muscle weakness s, hearing issues, and hi			
		dated April 30, 2021, ind es including medication general cleaning.	licated		
	2022, C4 was orier	Assessment, dated April 2 Inted to person, place and ties including visual diffic	d time,		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	5378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
0 810	hearing difficulties, adaptations in the k measures to be tak abuse to himself ar addition, the assess no aggressive beha lacked a review of another individual, adults or minors, at C1 C1's diagnoses inc humerus, bradycar fibrillation (abnorma (fainting, blacking of C1's Service Plan of C1 received assista administration, bath laundry, linen chan transportation. C1's Vulnerability A 17, 2022, indicated memory loss. This included the client's vulnerable adults o measure to be take abuse; however, th susceptibility to self individual. C3	had chronic pain, and had no bathroom, and noted specific ten to minimize the risk of ad other vulnerable adults. In sment indicated C4 displayed aviors toward others; however, C4's susceptibility to abuse by including other vulnerable and susceptibility to self-abuse. Inded closed fracture left distand dia (slow heart rate), atrial al heart rate), and syncope but, passing out). dated July 16, 2021, indicated ance with medication hing assist, general cleaning, ge, companionship, and ssessment, dated November C1 had recent short term Vulnerability Assessment a risk of abusing other r minor and a specific en to minimize the risk of is plan failed to include C1's f-abuse and abuse by another				
	(increase fluid reter (inflammation of the	luded bilateral leg edema ntion to both legs), pancreatitis e pancreas), and chronic adual loss of kidney function).				
		lated June 14, 2022, indicated ance with support stocking,				

STATE FORM

TZD211

If continuation sheet 4 of 55

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	3378		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
0 810	Continued From pa	age 4	0 810			
	nurse visits, genera change, and compa	al cleaning, laundry, linen anionship.				
	2022, indicated C3 chronic conditions/ Vulnerability Asses of abusing other vu specific measure to of abuse; however,	Assessment, dated June 14, had visual difficulties and pain/illness/disability. C3's sment included the client's risk ilnerable adults or minor and a b be taken to minimize the risk , the plan failed to include C3's f-abuse and abuse by another	1 5			
	(RN)-A stated she s January 2023, and requirement to revi abuse by another in electronic assessm required content, th	t 1:31 p.m., registered nurse started at the agency in was not aware of the ew the client's susceptibility to ndividual. RN-A stated the nent did not include the nerefore was not included in sessment for any of the clients				
	Reporting policy, re the agency would of abuse prevention p that would contain a - the client's suscep individual (including - the client's risk of adults; and - actions, measures would take to minin client and other vul Also included, whe	munication, Prevention, and evised April 26, 2017, indicated develop an individualized blan for each home care client a review of: ptibility to abuse by another g other vulnerable adults); abusing other vulnerable s, or approaches the agency nize the risk of abuse to the nerable adults. n appropriate, the plan would				
	also address the is No further informat	sue of client self-abuse.				

Minnesota Department of Hea

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	STREET S NTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ES ID PROVIDER'S PLAN OF C 7 FULL PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLET DATE
0 810	Continued From pa	ge 5	0 810			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 860 SS=F	144A.4791, Subd. 8 and Monitoring	3 Comprehensive Assessment	0 860			
	comprehensive hor individualized initial conducted in perso the services are pro professionals, the a conducted by the a This initial assessm five days after the c are first provided. (b) Client monitorin conducted in the cli days after the date first provided. (c) Ongoing client m must be conducted in the needs of the days from the last of monitoring and reas at the client's reside of telecommunication	ces being provided are me care services, an assessment must be n by a registered nurse. When ovided by other licensed health assessment must be ppropriate health professional. nent must be completed within late that home care services g and reassessment must be ent's home no more than 14 that home care services are nonitoring and reassessment as needed based on changes client and cannot exceed 90 late of the assessment. The sessment may be conducted ence or through the utilization on methods based on practice it the individual client's needs.				
	by: Based on observati review, the licensee completion of requi registered nurse (R assessment within services were first p (C1), client monitor	ent is not met as evidenced on, interview and record e failed to ensure timely red assessments by the N) for an individualized initial five days after the date that provided for one of four clients ing and reassessment no after the date that services				

TZD211

If continuation sheet 6 of 55

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		I STREET S ENTRE, MN 56	5378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
0 860	Continued From pa	ge 6	0 860			
		and on-going assessments ays, for four of four clients (C1,				
	violation that did no safety but had the p client's health or sa cause serious injur was issued at a wic problems are perva failure that has affe	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has the potential to on or all of the clients).				
	The findings include	e:				
	at 10:14 a.m., RN-A initial assessment of admission and state for the clients that w (VA) recipients were	e conference on April 4, 2023, A stated she completed the on the day of the client's ed subsequent assessments were Veterans Administration e completed every 60 days re "private pay" were 0 days.				
		ate was July 16, 2021, ient Data form provided by the 2023.				
	humerus, bradycar	luded closed fracture left distal dia (slow heart rate), atrial al heart rate), and syncope out, passing out).				
	C1 received assista administration, bath	dated July 16, 2021, indicated ance with medication ning assist, general cleaning, ge, companionship, and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		I STREET S ENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
0 860	Continued From pa	age 7	0 860			
	visit, the surveyor o	t 11:30 a.m., during a home observed RN-A while she l signs and provided services.				
	identified as the init	ed a Client Assessment Form, tial assessment, dated 2. C1's record lacked any sive assessments.				
	five days after the of were first provided, in the client's home the date that home provided, and lacke and reassessment	an initial assessment within date that home care services monitoring and reassessment on more than 14 days after care services were first ed ongoing client monitoring not to exceed 90 days from assessment, as required.				
	initial assessment	t 2:11 p.m., RN-A stated C1's was dated November 17, 2022 essments completed.	,			
	13, 2022, with diag edema (increase fli pancreatitis (inflam	g home care services on June noses including bilateral leg uid retention to both legs), mation of the pancreas), and ease (gradual loss of kidney				
	C3 received assista	dated June 14, 2022, indicated ance with support stocking, al cleaning, laundry, linen anionship.				
	visit, the surveyor o	t 7:30 a.m., during a home observed while unlicensed provided assistance with				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	- INC	TH STREET S CENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 860	Continued From pa	age 8	0 860			
		ion stockings, bed making, linds, opening jars on the g the garbage out.				
	identified as the ini	ed a Client Assessment Form tial assessment, dated June ord lacked any further	l,			
	in the client's home the date that home provided and lacke and reassessment	monitoring and reassessme e no more than 14 days after care services were first ed ongoing client monitoring not to exceed 90 days from assessment, as required.				
	initial assessment of no further assessment documented. RN-A day, 90 day and ch assessments for th clients. RN-A state the licensee in Jan of the requirements	A stated she oversees initial, ange of condition he licensee's comprehensive d she started employment wi uary 2023, and was not awar s for client assessments. RN g along with what someone	th 14 th			
	24, 2018, with diag	g home care services on July noses including muscle s, and chronic pain.	,			
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated July 23 received services including ement with medication set-up ousekeeping.				
	During a home visi	t on April 4, 2023, at 12:15				

STATE FORM

TZD211

If continuation sheet 9 of 55

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	· INC	H STREET S ENTRE, MN 56	5378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 860	Continued From pa	age 9	0 860			
	C2's medications a	observed while RN-A set up nd completed wound care to a d scabbed area on the outside right great toe.				
	dated July 24, 2018	ed a Client Assessment Form, 3, and March 23, 2022. C2's further comprehensive				
	reassessment not t	ongoing client monitoring and to exceed 90 days from the essment, as required.				
		luded muscle weakness, s, hearing issues, and history				
		dated April 30, 2021, indicated es including medication general cleaning.				
	the surveyor observe	t on April 4, 2023, at 3:15 p.m. ved while licensed practical up C4's medications and	,			
	dated April 30, 202	ed a Client Assessment Form, 1, and April 28, 2022. C4's further comprehensive				
	reassessment not t	ongoing client monitoring and to exceed 90 days from the essment, as required.				
	started employmen	t 1:31 p.m., RN-A stated she It with the licensee in January erstanding was she was to				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 860	started services, if t condition, and when stated, "I don't think	ge 10 assessment when the client there was a change in n the client discharged. RN-A c I've been scheduled to see a	0 860			
	Monitoring, and Re March 2023, indicat provided were com services, an individ conducted in-perso initial assessment r days after initiation included, client mon must be conducted than 14 days after i ongoing client mon be conducted as ne the needs of the clie days from the last of No further information					
0 865 SS=D	(21) days144A.4791, Subd. 9Implementation & F(a) No later than 14care services are fi		0 865			
	include a signature home care provider client's representati	n and any revisions must or other authentication by the and by the client or the ve documenting agreement be provided. The service plan				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		STREET S	3378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 865	Continued From pa	ge 11	0 865			
	review or reassess 8. The provider muclient about change services and how to Ombudsman for Lo (c) The home care provide all services service plan. (d) The service plan must be entered int notice of a change applicable. (e) Staff providing h informed of the cur This MN Requirem by: Based on observat review, the licensee plan was revised w one of four clients (This practice result violation that did no safety but had the p client's health or sa cause serious injur was issued at an is limited number of c limited number of s situation has occur The findings include	provider must implement and required by the current in and revised service plan to the client's record, including in a client's fees when home care services must be rent written service plan. ent is not met as evidenced ion, interview, and record e failed to ensure the service ith the changes in services for C2). ed in a level two violation (a t harm a client's health or botential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). e: luded muscle weakness,				
		dated July 24, 2018, indicated es including a "one time" initial				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED			
		H30189	B. WING		04/	06/2023			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE					
ALTERNATIVE SENIOR CARE, INC 418 10TH STREET S SAUK CENTRE, MN 56378									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE			
0 865	Continued From pa	age 12	0 865						
	set up and monitor housekeeping and by the unlicensed p Modification To The December 3, 2019 services to include services to twice w extra RN visit per w for wound care. C2 Plan, dated July 23 assessment by the RN once weekly, tw and an increase to the RN. C2's Modifi dated August 10, 2	linen change every Thursday bersonnel (ULP). C2's e Service Plan, dated , indicated a change in an increase in housekeeping eekly and an increase of an veek until December 18, 2019, 's Modification To The Service 6, 2020, indicated a "one time" RN, medication set up by the vice weekly housekeeping, and twice weekly wound care by ication To The Service Plan, 021, indicated an addition of ULP services and up to 30							
	p.m., the surveyor of C2's medications a large, round shape of the base of C2's that he had an app the end of the prev changes to dressin he was started on of to infection to the a	t on April 4, 2023, at 12:15 observed while RN-A set up nd completed wound care to a d scabbed area on the outside right great toe. C2 reported ointment at the wound clinic at ious week, and there were no g the wound; however stated oral antibiotics for 10 days, due rea. RN-A removed the rolled ound C2's right foot and							
	needed to dampen the gauze from the area on the top of t a foot bathing devic he placed both feet several minutes, R feet from the water wounds with a salir	the gauze with water to looser scabbed area and an open he second toe. RN-A brought ce, filled with water, to C2 and t in the water to soak. After N-A assisted C2 to remove his dried his feet, sprayed the he spray, applied an antibiotic a, and applied bandages.							

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		H30189	B. WING		04/06/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ALTERNATIVE SENIOR CARE, INC 418 10TH STREET S SAUK CENTRE, MN 56378							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
0 865	Continued From pa	age 13	0 865				
	was performed by the stated she performed by the stated she perform week when she set and his wife completion the week. On April 6, 2023, at manager (CCM)-D developing and revers and stated she was client admissions to the service plan. Co orders for C2's would been to the doctor, doing wound care at nurse. When asked wound care noted of could not explain whim once weekly for the service of the service plan.	ce plan indicated wound care the RN twice weekly, RN-A ed the wound care once a t up C2's medications, and C2 eted the wound care the rest of t 11:10 a.m., client care stated she was responsible for ising the clients' service plans is not a nurse but attended o gather information to create CM-D stated she could not fin- und care because C2 had not and stated RN-A was just as directed by the previous d about the twice weekly on the service plan, CCM-D <i>y</i> hy the nurse was only seeing or wound care or why the ot been revised to indicate	of ,				
	CCM-D was in cha plan, and stated, as no orders for woun compliant and wou the wound. RN-A s visits to C2, becaus nurse was doing. R of the twice weekly service plan. The licensee's Service	t 1:31 p.m., RN-A stated rge of completing the service s far as she knew, there were d care because C2 was not ld not go to see his provider for tated she was making weekly se that's what the previous RN-A indicated not being aware wound care noted on the vice Plan Modification policy,					
	dated July, 2019, ir was the responsible modification, and d agreement must be	ndicated the registered nurse e staff for the service plan lirected if the service plan or e modified due to a change in or a change in the client's	a				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/06/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ALTERN	IATIVE SENIOR CARE		I STREET S ENTRE, MN 56	3378		
(X4) ID			ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
0 865	Continued From pa	ge 14	0 865			
	Agreement must be	difications to the Service completed and signed by the responsible person.				
	No further informat	ion was provided.				
	TIME PERIOD TO days.	CORRECT: Twenty-one (21)				
0 870 SS=F	0 144A.4791, Subd. 9	9(f) Content of Service Plan	0 870			
	provided, the fees f of each service, ac review or assessme (2) the identification staff who will provid (3) the schedule an reviews or assessm (4) the schedule an providing home car (5) a contingency p (i) the action to be f provider and by the representative if the provided; (ii) information and client's representat provider; (iii) names and con client wishes to hav if there is a significa- client's condition; a (iv) the circumstand medical services an consistent with cha	the home care services to be for services, and the frequency cording to the client's current ent and client preferences; n of the staff or categories of le the services; id methods of monitoring nents of the client; id methods of monitoring staff re services; and lan that includes: taken by the home care client or client's e scheduled service cannot be a method for a client or twe to contact the home care tact information of persons the ve notified in an emergency or ant adverse change in the				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		H30189	B. WING		04/06/2023	
	PROVIDER OR SUPPLIER		.DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	3378		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	CIENCIES ID PROVIDER'S P		TION SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO 1 DEFICIENC		DATE
0 870	Continued From pa	ige 15	0 870			
	by: Based on interview licensee failed to en	ent is not met as evidenced and record review, the nsure the service plan include the for four of four clients (C2,	d			
	violation that did no safety but had the p client's health or sa cause serious injur was issued at a wic problems are perva	ed in a level two violation (a bt harm a client's health or botential to have harmed a lifety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic boted or has potential to affect II of the clients).				
	The findings includ	e:				
	following content:	B's service plans lacked the oring staff supervision.				
		y home care services on July noses including muscle s, and chronic pain.				
	Modification To The 2020, indicated C2 medication manage wound care, and he Plan lacked the me	dated July 24, 2018, and e Service Plan, dated July 23, received services including ement with medication set-up, busekeeping. C2's Service whods of monitoring staff re services, as required.				
		luded muscle weakness, s, hearing issues, and history				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
ALTERN	ATIVE SENIOR CARE	. INC	STREET S	co 70		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
0 870	Continued From pa	ge 16	0 870			
	of stroke.					
	C4 received service management and g Plan lacked the me	dated April 30, 2021, indicated es including medication jeneral cleaning. C4's Service thods of monitoring staff e services, as required.				
	humerus, bradycar	luded closed fracture left distal dia (slow heart rate), atrial al heart rate), and syncope but, passing out).				
	C1 received assista administration, bath laundry, linen chang transportation. C1's	dated July 16, 2021, indicated ance with medication ning assist, general cleaning, ge, companionship, and Service Plan lacked the ring staff providing home care ed.				
	(increase fluid reter (inflammation of the	uded bilateral leg edema ntion to both legs), pancreatitis e pancreas), and chronic idual loss of kidney function).				
	C3 received assista nurse visits, genera change, and compa	dated June 14, 2022, indicated ance with support stocking, al cleaning, laundry, linen anionship. C3's Service Plan s of monitoring staff providing s, as required.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 870	-	age 17 t 2:51 p.m., client care	0 870			
	manager (CCM)-D admissions, with th service plans base needs. CCM-D indi not include the met providing home car	stated she attended client e nurse, and developed the d on the identified clients' icated she the service plan did thods of monitoring staff re services and stated the ate was the same form used	t			
	2019, indicated the written service plan that home care ser client, and must ind required elements: - a description of th provided, the fees to of each service; - the identification of provide services; - the schedule and reviews or assess - the schedule and	vice Plans policy, dated July elicensee would finalize a in within 14 days after the date vices were first provided to the clude all of the following ne home care services to be for services, and the frequenc of the type of staff that would methods of monitoring nents of the client; and methods of monitoring nel providing home care	e			
	services. No further informat	ion was provided.				
	TIME PERIOD FOI Twenty-One (21) d					
0 910 SS=D	144A.4792, Subd. Monitoring/Reasse	3 Individualized Medication ss	0 910			
	monitor and reasse management servi	e home care provider must ess the client's medication ces as needed under the client presents with				

STATE FORM

If continuation sheet 18 of 55

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		H30189	B. WING		04/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 910	Continued From pa	age 18	0 910			
		issues that may be and, at a minimum, annually.				
	by:	ent is not met as evidenced				
	review, the license registered nurse (F medication manage	ion, interview, and record e failed to ensure the RN) conducted a face-to-face ement reassessment at least the required content, for one				
	violation that did no safety but had the client's health or sa cause serious injur was issued at an is limited number of c limited number of s	ted in a level two violation (a bt harm a client's health or potential to have harmed a afety, but was not likely to y, impairment, or death), and colated scope (when one or a clients are affected or one or a staff are involved or the red only occasionally).	1			
	The findings includ	e:				
	at 9:00 a.m., RN-A (CCM)-D stated the	e conference on April 4, 2023, and client care manager e agency provided medication ces to their clients, including				
	C2's diagnoses inc diabetes, and chro	luded muscle weakness, nic pain.				
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated July 23, received services including ekeeping, and medication medication set up.				
	C2's signed medica	ation orders, dated March 23,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H30189	B. WING		04/	04/06/2023	
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
LTERN	ATIVE SENIOR CARE		STREET S NTRE, MN 56	378			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 910	thinners, two oral are blood glucose), an are cholesterol), an ant sleep aide, two anti blood pressure), an fluid). During a home visit p.m., the surveyor of C2's medications are large, round shaped of the base of C2's C2's Client Assess C2's Client Assess 2022 (over one yea Assessment and M indicated the most at the client was taking nurse, reviewed for name, dose, freque potential allergic or and side effects. Als indicated C2 was par medications from p agency nurse; how compliant with takin needed frequent rea importance of taking C2's record lacked lacked evidence the	was currently taking two blood ntihyperglycemics (treats high antihyperlipidemic (treat high idepressant, supplements, a hypertensives (treat high d a diuretic (decrease excess on April 4, 2023, at 12:15 observed while RN-A set up nd completed wound care to a d scabbed area on the outside right great toe. ment Form, dated March 23, r ago), included Medication anagement Plan, which accurate list of all medications g had been reviewed by a contraindications, medication ncy, and route, reviewed adverse reactions, indications so included, the assessment artially able to self-administer reset trays, set up by the ever, was not always og the medications and education regarding the g medications prescribed. any further assessments and e RN conducted a face-to-face ing and reassessment dications;	0 910				

STATE FORM

TZD211

If continuation sheet 20 of 55

STATEMEI	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/06/2023	
		H30189	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	378		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
0 910	started employmen 2023, and her unde complete an initial a medication manage client started servic condition, and wher indicated she was r monitoring and reas conducted annually No further informati	t with the licensee in January erstanding was she was to assessment, including ement assessment, when the res, if there was a change in n the client discharged. RN-A not aware medication ssessment needed to be	0 910			
0 920 SS=D	Mgt Plan (a) For each client r management servic care provider must service plan a writte management servic client. The provider current individualize record for each clie assessment that m (1) a statement des management servic (2) a description of on the client's need diversion, and cons directions; (3) documentation of relating to the admi (4) identification of monitoring medicat medication refills ar	5 Individualized Medication receiving medication ces, the comprehensive home prepare and include in the en statement of the medication ces that will be provided to the must develop and maintain a ed medication management nt based on the client's ust contain the following: scribing the medication ces that will be provided; storage of medications based s and preferences, risk of istent with the manufacturer's of specific client instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/06/2023	
		H30189	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	IATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	I STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE
0 920	Continued From pa	ge 21	0 920			
	 personnel; (6) procedures for sonurse or appropriate when a problem arite management service (7) any client-specified documenting medicies verifications that all as prescribed, and to prevent possible reactions. (b) The medication current and updated changes. (c) Medication recommended and the professional, or aute medication manage This MN Requiremend by: Based on observation review, the licenseed updated individualize plan was developed required content for This practice resulted violation that did no safety but had the pclient's health or saic cause serious injury was issued at an issue limited number of columnation of safety number of safety number of columnation of safety number of columna	ces; and fic requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed rse, licensed health horized prescriber is providing ement. ent is not met as evidenced on, interview and record e failed to ensure a current and ted medication management d and maintained with all the one of four clients (C2). ed in a level two violation (a t harm a client's health or botential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	H30189	B. WING		04/	06/2023
OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IVE SENIOR CARE	INC		378		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
During the entrance at 9:00 a.m., register care manager (CCM provided medication heir clients, includin C2's diagnoses incl liabetes, and chron C2's Service Plan, of Addification To The 2020, indicated C2 vound care, housel nanagement with n C2's signed medica 2023, indicated C2 hinners, two oral an blood glucose), an a cholesterol), an anti- blood glucose), an a cholesterol), an anti- blood pressure), an luid). During a home visit c.m., the surveyor of C2's medications and arge, round shaped of the base of C2's C2's Client Assessr 2022 (over one yea Assessment and M described the medica- pering provided, des nedications, specif	e conference on April 4, 2023, ered nurse (RN)-A and client M)-D stated the agency in management services to ing medication setup. uded muscle weakness, nic pain. dated July 24, 2018, and e Service Plan, dated July 23, received services including keeping, and medication nedication set up. tition orders, dated March 23, was currently taking two blood ntihyperglycemics (treat high antihyperlipidemic (treat high idepressant, supplements, a hypertensives (treat high d a diuretic (decrease excess on April 4, 2023, at 12:15 observed while RN-A set up nd completed wound care to a d scabbed area on the outside right great toe. nent Form, dated March 23, r ago), included Medication anagement Plan, which cation management services scription of the storage of ic client instructions,		DEFICIENC		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa During the entrance at 9:00 a.m., registe care manager (CCM provided medication heir clients, includin C2's diagnoses incl diabetes, and chror C2's Service Plan, of Modification To The 2020, indicated C2 vound care, housel nanagement with n C2's signed medica 2023, indicated C2 vound care, housel nanagement with n C2's signed medica 2023, indicated C2 hinners, two oral at plood glucose), an at cholesterol), an ant sholesterol), an ant sholesterol), an ant sholesterol, an ant plood pressure), an luid). During a home visit o.m., the surveyor of C2's medications at arge, round shaped of the base of C2's C2's Client Assess 2022 (over one yea Assessment and M described the medic pendications, specif dentification of pers	F CORRECTION IDENTIFICATION NUMBER: H30189 H30189 OVIDER OR SUPPLIER STREET A TIVE SENIOR CARE, INC 418 10Tl SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SAUK C Continued From page 22 Ouring the entrance conference on April 4, 2023, at 9:00 a.m., registered nurse (RN)-A and client care manager (CCM)-D stated the agency provided medication management services to heir clients, including medication setup. C2's diagnoses included muscle weakness, liabetes, and chronic pain. C2's Service Plan, dated July 24, 2018, and Modification To The Service Plan, dated July 23, 2020, indicated C2 received services including vound care, housekeeping, and medication nanagement with medication set up. C2's signed medication orders, dated March 23, 2023, indicated C2 was currently taking two blood hinners, two oral antihyperlipidemic (treat high blood glucose), an antihyperlipidemic (treat high blood glucose), an antihyperlipidemic (decrease excess luid). During a home visit on April 4, 2023, at 12:15 During a home visit on April 4, 2023, at 12:15 Durin, the surveyor observed while RN-A set up C2's medications and completed wound care to a arge, round shaped scabbed area on the outside of the base of C2's right great toe. C2's Client Assessment Form, dated March 23, 2022 (over one year ago), included Medication Assessment and Management Plan, which lescribed the medication management services being provided, description of the storage of nedications, specific	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: H30189 B. WING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TVE SENIOR CARE, INC 418 10TH STREET S SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDERS PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D During the entrance conference on April 4, 2023, tt 9:00 a.m., registered nurse (RN)-A and client are manager (CCM)-D stated the agency rovided medication management services to heir clients, including medication setup. 0 920 22's diagnoses included muscle weakness, liabetes, and chronic pain. 22's diagnoses included muscle weakness, liabetes, and chronic pain. 22's Service Plan, dated July 24, 2018, and Modification To The Service Plan, dated July 23, 0020, indicated C2 received services including wound care, housekeeping, and medication nanagement with medication set up. C2's signed medication orders, dated March 23, 1020 pressure), and a diuretic (decrease excess luid). During a home visit on April 4, 2023, at 12:15 p.m., the surveyor observed while RN-A set up 2's medications and completed wound care to a arge, round shaped scabbed area on the outside of the base of C2's right great toe. 2's Client Assessment Form, dated March 23, 0022 (over one year ago), included Medication Sessesment and Management Fan, which lescribed the medication management services be	ECORRECTION IDENTIFICATION NUMBER: A. BUILDING: 04/ OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 04/ OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 04/ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCE) TO THE SERVICE TO ITHE APPROPRIATE DEFICIENCY) Continued From page 22 0 920 During the entrance conference on April 4, 2023, tt 9:00 a.m., registered nurse (RN)-A and client rare manager (CCM)-D stated the agency rovided medication magement services to heir clients, including medication setup. 0 920 0920 22's Service Plan, dated July 24, 2018, and dodification To The Service Plan, dated July 23, vound care, housekeeping, and medication nanagement with medication orders, dated March 23, vound care, housekeeping, and medication seesing the workit on April 4, 2023, at 12:15 ym., the surveyor observed while RN-A set up 22's medications and completed wound care to a arge, round shaped scabbed area on the outside of t

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED		
		H30189	B. WING		04/06/2023			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE				
ALTERNATIVE SENIOR CARE, INC 418 10TH STREET S SAUK CENTRE, MN 56378								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
0 920	Continued From pa	age 23	0 920					
	medication manage following required of - statement describ management servio - description of stor the client's needs a diversion, and cons directions; - documentation of related to the admin - identification of per monitoring medication medication refills w - identification of m that may be delegan personnel); - procedures for sta (RN) when a proble management servio - any client-specific documenting medication verifications that all administered as pro medication use to p or adverse reaction On April 6, 2023, and started employmen 2023, and her under complete an initial a medication manage client started servio condition, and whe indicated not know medication manage	bing the medication ces that would be provided; rage of medications based on and preferences, risk of sistent with the manufacturer's specific client instructions nistration of medications; ersons responsible for tion supplies and ensuring that rere ordered on a timely basis; edication management tasks ted to ULP (unlicensed aff to notify a registered nurse em arose with medication ces; and requirements related to cation administration, medications were escribed, and monitoring of prevent possible complications is. t 1:31 p.m., RN-A stated she it with the licensee in January erstanding was she was to assessment, including ement assessment, when the ces, if there was a change in in the client discharged. RN-A ing that a current individualized ement plan must be developed each client based on the						

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED			
		H30189	H30189 B. WING		04/06/2023				
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE					
ALTERNATIVE SENIOR CARE, INC 418 10TH STREET S SAUK CENTRE, MN 56378									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
0 920	Continued From pa	ge 24	0 920						
	TIME PERIOD FOF	R CORRECTION: Seven (7)							
0 935 SS=D	144A.4792, Subd. 8 Administration of M		0 935						
	Each medication administered by comprehensive home care provider staff must be documented in the client'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 client's needs when medication was not administered as prescribed and in compliance with the client'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 transcribed as ordered for one of four clients (C1), and failed to ensure medications were administered as ordered for one of two clients (C1).								
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an iss limited number of c	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the							

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
		H30189	B. WING		04/	06/2023		
NAME OF I	PROVIDER OR SUPPLIER	418 10TH STREET S						
ALTERN	ATIVE SENIOR CARE	F. INC	H STREET S ENTRE, MN 50	6378				
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	FION SHOULD BE	(X5) COMPLET		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE		
0 935	Continued From pa	age 25	0 935					
	situation has occur	red only occasionally).						
	The findings includ	e:						
	humerus, bradycar	luded closed fracture left dista dia (slow heart rate), atrial al heart rate), and syncope out, passing out).						
	C1 received assistant administration, bath	dated July 16, 2021, indicated ance with medication hing assist, general cleaning, ge, companionship, and						
	visit the surveyor o	t 11:30 a.m., during a home bserved registered nurse omplete set of vitals and services.						
	however, C1's med 2023, included: - Tylenol 500mg tal milligrams (mg)) by tablets (1,000 mg) mg) before bedtime	signed medication orders; dication list, dated March 9, ke two tablets (1,000 / mouth in the morning and two at noon and two tablets (1,000 e; ake 1 tablet by mouth every						
	- Caltrate-600+D 60 (400 units) take on with breakfast and - Pradaxa 150 mg t the morning and ev	take one capsule by mouth in						
	- lisinopril take one morning;	tablet by mouth in the ate 50 mg take three tablets						

STATE FORM

linnesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	H30189	B. WING		04/06/2023	
AME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LTERNATIVE SENIOR CARE	F INC	I STREET S ENTRE, MN 50	6378		
	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
0 935 Continued From pa	age 26	0 935			
 every morning; oxycodone 5 mg as needed for severed. Mirilax take 17 gr. sennosdies-docus: mouth once daily; a Zocor 10 mg daily. C1's MAR (medicad dated March 2023, medications; howe following: Tylenol 500 mg or as needed; Mirilax 17 grams senna-docusate seneeded; and ibuprofen 200 mg hours, as needed. In addition, the following: as needed. In addition, the following: as needed for severe morning; and correspondent to a series and severe morning; and correspondent to a series and series	am's by mouth once daily; sate sodium take one tablet by and v at bedtime. tion administration record) included the above ver, also included the ne tab every four to six hours once daily as needed; sodium one tab once daily as one to two tabs every six owing medications were not vR: ds 1000 mg take one capsule take one tablet every 4 hours				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		H30189	B. WING		04/06/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	3378			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
0 935	medications for age cares; but a signatu is requested annua date. RN-A stated, someone was tellin The agency's 5.01 Orders policy dated RN is responsible for authorized prescrib treatments adminis clients' record, No further information	ency's clients upon start of ure from the medical provider lly from client's start of care "I was going along with what g me earlier". Medication and Treatment I July 7, 2019, indicated the or assuring that current, er orders for medications and tered to be kept on file in	0 935				
0 940 SS=F	name of medication administered, route of person completin done at the time of This MN Requireme by: Based on interview licensee failed to en medication setup in content for three of This practice result violation that did no safety but had the p client's health or sa	lates of medication setup, n, quantity of dose, times to be of administration, and name ng medication setup must be	0 940				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		H30189	B. WING	B. WING		06/2023
IAME OF F	PROVIDER OR SUPPLIER		EET ADDRESS, CITY, S		04/	00/2023
	ATIVE SENIOR CARE	418	10TH STREET S			
	ATTVE SENIOR CARE	SAU	IK CENTRE, MN 5	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
0 940	Continued From pa	age 28	0 940			
	problems are perva	despread scope (when asive or represent a syster acted or has potential to aff Il of the clients).				
	The findings includ	e:				
	at 9:00 a.m., regist care manager (CC provided medicatio	e conference on April 4, 20 ered nurse (RN)-A and clie M)-D stated the agency n management services to ing medication setup.	ent			
	C2 C2's diagnoses inc diabetes, and chron	luded muscle weakness, nic pain.				
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated July received services includin ekeeping, and medication medication set up.				
	2022, included Mee Management Plan, partially able to self	ment Form, dated March 2 dication Assessment and which indicated C2 was f-administer medications fr b by the agency nurse.				
	2023, indicated C2 thinners, two oral a blood glucose), an cholesterol), an and sleep aide, two ant	ation orders, dated March was currently taking two b intihyperglycemics (treats l antihyperlipidemic (treat h tidepressant, supplements ihypertensives (treat high nd a diuretic (decrease exc	blood high igh , a			
		t on April 4, 2023, at 12:15 observed while RN-A set u				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
0 940	Continued From pa	age 29	0 940			
		nd completed wound care to a d scabbed area on the outside right great toe.				
	Record (MAR), data medications were s February 14, 2023 2023 (8 days later), days later), by RN-/ (LPN)-B, with initial RN-A noted on the "2/28/23: end of mo Meds [medications] C2's record lacked	ofile/Medication Administration ed February 2023, indicated set up on February 7, 2023, (7 days later), February 22, , and February 28, 2023 (6 A and licensed practical nurse s noted on those dates, and bottom of page 1 of 15, onth review meets compliance.] are set up weekly by nurse." documentation at the time of e dates of the medications set				
	always signs her in that she is at the ho	t 1:28 p.m., RN-A stated she itials on the MAR on the date ome and sets up C2's besn't indicate how many days h medication.				
		luded muscle weakness, s, hearing issues, and history				
		dated April 30, 2021, indicated es including medication general cleaning.				
	2022, included Mec Management Plan, partially able to self	ment Form, dated April 28, dication Assessment and which indicated C4 was f-administer medications from by the agency nurse.				
nnosota D	C4's signed medica	ation orders, dated March 8,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		ATE SURVEY OMPLETED	
		H30189	B. WING		04/	06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
LTERN	ATIVE SENIOR CARE	F. INC	TH STREET S	2270			
			CENTRE, MN 5	PROVIDER'S PLAN OF	CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 940	Continued From pa	age 30	0 940				
	supplements, a blo antihypertensives, medication to treat During a home visi the surveyor obser medications and as C4's Medication Pr Record, dated Mar	t on April 4, 2023, at 3:15 p.m ved while LPN-B set up C4's	n., on ns				
	days later), March March 28, 2023 (7 initials noted on the the bottom of page month review meet [medication] tray S [sic] administrats [s appropriately." C4's	21, 2023 (7 days later), and days later), by LPN-B, with h ose dates, and LPN-B noted of a 1 of 11, "3/31/23: End of ts compliance for weekly med et up by nurse & client selfs sic] from pre-set tray s record lacked documentation p to include the dates of the	er on d.				
	care plan directed set up, typically we how many days sh signs her initials or sets up the medica	t 3:55 p.m., LPN-B stated the when medications should be ekly or biweekly, and that's e sets up. LPN-B stated she the MAR, on the date that sl tions but does not indicate e has set up each medication	he				
	humerus, bradycar	cluded closed fracture left dist dia (slow heart rate), atrial al heart rate), and syncope out, passing out).	al				
	C1's service plan d	lated July 16, 2021, indicated					

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ATIVE SENIOR CARE		H STREET S ENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
0 940	Continued From pa	ge 31	0 940			
	administration, bath	ance with medication ning assist, general cleaning, ge, companionship, and				
	however, C1's Med Management Plan identified C1 requir nurse for: two analog three supplements, medication to treat	signed medication orders; ication Assessment and dated November 17, 2022, ed medication set up by a gesics, two antihypertensives, one blood thinner, one hypothyroid, one medication t ol and two laxatives.	0			
	visit the evaluator of	: 11:30 a.m., during a home bserved RN-A provide a ils and medication set up				
	record dated March were set up on Mar March 21, 2023; an and licensed practic documented on Ma review meets comp alarmed med whee record lacked docu	ofile/medication administration a 2023, indicated medications och 7, 2023; March 14, 2023; ad March 28, 2023, by RN-A cal nurse (LPN)-B. RN-A urch 31, 2023 "end of month bliance. Meds set up weekly in I by nurse". However, C1's mentation by RN-A and LPN-I to include the medication				
	Dosage Box Set Up indicated when the setting up the medi the set-up would be	lication Administration-Weekly o policy, revised March 2023, licensed nurse had completed cations into the dosage box, e documented on the MAR; lacked direction of the ation content.				
	No further informat	ion was provided.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			
		H30189	B. WING		04/	06/2023
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LTERN	ATIVE SENIOR CARE		I STREET S			
		SAUK C	ENTRE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
0 940	Continued From pa	age 32	0 940			
	TIME PERIOD FOI	R CORRECTION: Seven (7)				
0 965 SS=D	144A.4792, Subd.	13 Prescriptions	0 965			
	recorded prescripti 151.01, subdivisior	urrent written or electronically on as defined in section 16a, for all prescribed e comprehensive home care on for the client.				
	by: Based on interview licensee failed to e	ent is not met as evidenced and record review, the nsure written or electronically ons were obtained for one of				
	violation that did no safety but had the resident's health or cause serious injur was issued at an is limited number of a limited number of	ed in a level two violation (a ot harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or f staff are involved or the red only occasionally).	-			
	The findings includ	e:				
	humerus, bradycar	luded closed fracture left dista dia (slow heart rate), atrial al heart rate), and syncope out, passing out).				
	C1 received assista	ated July 16, 2021, indicated ance with medication ning assist, general cleaning,				

TZD211

If continuation sheet 33 of 55

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H30189	B. WING	B. WING		04/06/2023	
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE			
LTERN	ATIVE SENIOR CARE	INC	TH STREET S CENTRE, MN 56	5378			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 965	Continued From pa	ige 33	0 965				
	laundry, linen chang transportation.	ge, companionship, and					
	visit the surveyor ol	t 11:30 a.m., during a home bserved registered nurse omplete set of vitals and services.					
	however, C1's med 2023, included: - Tylenol 500 mg ta milligrams (mg)) by tablets (1,000 mg) a mg) before bedtime - Fosamax 70 mg t week;	ake 1 tablet by mouth every					
	(400 units) take one with breakfast and - Pradaxa 150 mg t the morning and ev	take one capsule by mouth in					
	before breakfast;						
	 metoprolol succin once daily; omega-3 fatty acid 	ate 50 mg take three tablets ds 1,000 mg take one capsule	9				
	as needed for seve						
	- sennosdies-docus mouth once daily; a		y				
	- Zocor 10 mg daily						
		tion administration record) included the above					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		H30189	B. WING		04/	04/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
ALTERN	ATIVE SENIOR CARE	F INC	H STREET S ENTRE, MN 50	6378			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
0 965	Continued From pa	age 34	0 965				
	 Tylenol 500 mg of as needed; Miralax 17 grams senna-docusate sineeded; and ibuprofen 200 mg hours, as needed. In addition, the follo included on the MA omega-3 fatty aci every morning; and 	ds 1000 mg take one capsule 1 take one tablet every 4 hours					
	RN-A had oversigh management. RN-, medication orders signatures were re- medical provider po- stated current med followed by the me nursing home C1 v stated request of a medical provider of there was no proce medical providers a medical providers a medical providers a medications for ag- cares; but a signate is requested annua	t 2:11 p.m., RN-A reported t of clients medication A stated there were no signed for C1. RN-A stated no quested from the client's rior to March 9, 2023. RN-A lication management was dication list provided from the vas transferred from. RN-A signature was faxed to C1's n April 5, 2023. RN-A stated ess in place for request of signature for current ency's clients upon start of ure from the medical provider ally from client's start of care "I was going along with what ng me earlier".					
	Orders policy dated RN is responsible f authorized prescrib	Medication and Treatment d July 7, 2019, indicated the for assuring that current, per orders for medications and stered to be kept on file in					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LTERN	ATIVE SENIOR CARE		STREET S	6378		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
0 965	Continued From pa	ge 35	0 965			
	No further informat	ion was provided				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01010 SS=F	144A.4792, Subd. 2	22 Disposition of Medications	01010			
	the comprehensive given to the client of when the client's se management service service plan. Medic in the client's privat is deceased or that that have expired in the client's represe (b) The comprehen dispose of any medic comprehensive hor discontinued or exp the service contract according to state a disposition of medic substances. (c) Upon disposition care provider must record the dispositi the medication's na number as applicat	dications being managed by home care provider must be or the client's representative ervice plan ends or medication ces are no longer part of the sations that have been stored e living space for a client who have been discontinued or nay be given to the client or native for disposal. sive home care provider will dications remaining with the me care provider that are bired or upon the termination of t or the client's death and federal regulations for cations and controlled h, the comprehensive home document in the client's on of the medication including ume, strength, prescription ole, quantity, to whom the given, date of disposition, and other individuals involved in				
	by:	ent is not met as evidenced and record review, the				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01010	Continued From pa	ge 36	01010			
	medication includin prescription numbe and names of staff	rding the disposition of g the medication's strength, r, quantity, date of disposition, and other individuals involved r one of one discharged client				
	violation that did no safety but had the p client's health or sa cause serious injury is issued at a wides are pervasive or rep	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and spread scope (when problems present a systemic failure that the potential to affect a large clients).				
	The findings include	e:				
	C5 was discharged on October 4, 2022	from the home care provider				
		luded, dementia, type 2 d pressure, obesity, stroke,				
	C5 received service bathing, grooming, safety supervision,	dated May 9, 2022, indicated es including assistance with dressing, continence care, companionship, and ement including weekly				
	Record (MAR), date three antihypertens pressure), one antil	ofile/Medication Administration ed September 2022, included ives (treats high blood hyperglycemic (treats high itacid, two medications to a sleep aid.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	3378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01010	- 1	ige 37 s dated September 16, 2022,	01010			
	indicated C5's fami they had secured a facility because she	ly member called and stated unit for C5 at a health care couldn't be at home , home care services would be	e			
	disposition of media include the name o prescription numbe disposition, and the	documentation of the cations upon discharge to f the medication, strength, er if applicable, quantity, date c e names of staff and other l in the disposition, as	of			
	(RN)-A stated C5's medications with th	n the client's discharge and				
	revised March 2023 medications manag returned to the pha the client or the clie client's medications the home care prov disposition, the con provider must docu disposition of the m medication's name as applicable, quan were given, date of	bosal of Medication policy, 3, indicated current unused ged by the provider would be rmacy for credit, or given to ent's representative, when the s were no longer managed by vider. Also included, upon hprehensive home care ument in the client's record the hedication including the , strength, prescription numbe tity, to whom the medications disposition, and names of viduals involved in the	r			
	disposition.					
		R CORRECTION: Seven (7)				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/06/2023	
		H30189	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
		418 10T				
ALTERN	ATIVE SENIOR CARE		ENTRE, MN 56	5378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01010	Continued From pa	ige 38	01010			
	days					
	144A.4793, Subd. 3 Treatment/Therapy		01035			
	or prescribed treatr comprehensive hor and include in the s statement of the treat that will be provided must also develop a individualized treatr management recor- contain at least the (1) a statement of t provided; (2) documentation of relating to the treatr administration; (3) identification of will be delegated to (4) procedures for r appropriate license	d for each client which must following: he type of services that will be of specific client instructions	3			
	(5) any client-specific documentation of the received, verification therapy was admini- monitoring of treatmini- possible complication treatment or therap	fic requirements relating to reatment and therapy on that all treatment and istered as prescribed, and nent or therapy to prevent ons or adverse reactions. The by management record must ated when there are any				
	This MN Requirem by: Based on interview	ent is not met as evidenced				

TZD211

If continuation sheet 39 of 55

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01035	Continued From pa	nge 39	01035			
	treatment or therap	nsure an individualized y management plan was le the required content for two C3).				
	violation that did no safety but had the p client's health or sa cause serious injur was issued at a pat limited number of a limited number of	ed in a level two violation (a ot harm a client's health or potential to have harmed a lifety, but was not likely to y, impairment, or death), and ttern scope (when more than a clients are affected, more than f staff are involved, or the red repeatedly; but is not ive).	1			
	The findings includ	e:				
	at 9:56 a.m., opera care manager (CCI (RN)-A stated the li	e conference on April 4, 2023, tions manager (OM)-E, client M)-D, and registered nurse censee provided treatment gement services to their currer	ıt			
	C2 C2's diagnoses inc diabetes, and chroi	luded muscle weakness, nic pain.				
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated July 23, received services including keeping, and medication medication set up.				
	p.m., the surveyor of C2's medications a large, round shape	t on April 4, 2023, at 12:15 observed while RN-A set up nd completed wound care to a d scabbed area on the outside right great toe. C2 reported				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		H30189	B. WING		04/	04/06/2023	
	PROVIDER OR SUPPLIER		DDRESS, CITY, SI		04/	00/2023	
		418 10TF	I STREET S	IATE, ZIF CODE			
ALTERN	ATIVE SENIOR CARE		ENTRE, MN 56	5378			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
01035	Continued From pa	age 40	01035				
	the end of the previous changes to dressing he was started on of to infection to the algauze wrapped arouneeded to dampen the gauze from the area on the top of the placed both feet several minutes, RI feet from the water wounds with a saling ointment to each are Although the service was performed by the stated she performant week when she set	ointment at the wound clinic at ious week, and there were no g the wound; however stated oral antibiotics for 10 days, due rea. RN-A removed the rolled ound C2's right foot and the gauze with water to looser scabbed area and an open he second toe. RN-A brought ce, filled with water, to C2 and t in the water to soak. After N-A assisted C2 to remove his , dried his feet, sprayed the ne spray, applied an antibiotic rea, and applied bandages. the RN twice weekly, RN-A ed the wound care once a t up C2's medications, and C2 eted the wound care the rest or					
	and therapy manag written statement o include:	an individualized treatment gement plan to include a f all treatments to provide, to					
	provided; - documentation of relating to the treat administration;						
	will be delegated to - procedures for no appropriate license	eatment or therapy tasks that unlicensed personnel; tifying a registered nurse or d health professional when a n treatments or therapy					
pposoto D	 any client-specific documentation of tr 	requirements relating to reatment and therapy received treatment and therapy was	,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC .	0TH STREET S CENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01035	Continued From pa	age 41	01035			
	treatment or therap complications or ac treatment or therap be current and upd changes. C2's record lacked wound care being p On April 6, 2023, a as she knew, there wound care and the what someone told was not aware of a therapy management had previously refu for his wound beca result in amputation message for the wo	escribed, and monitoring of by to prevent possible dverse reactions. The by management record mus- lated when there are any prescriber orders for the brovided. t 1:50 p.m., RN-A stated, as were no orders for C2's at she was "going along with me prior." RN-A stated she in individualized treatment a ent plan for C2 and stated h ised to go to see the physici- use he was afraid it would n. RN-A stated she had left ound clinic after C2's eek, but had not received a	st s far h and le ian a			
	(increase fluid reter (inflammation of the	luded bilateral leg edema ntion to both legs), pancrea e pancreas), and chronic adual loss of kidney functior				
	C3 received assista	ated June 14, 2022, indicat ance with support stocking, al cleaning, laundry, linen anionship.	ed			
	On April 5, 2023, at	t 7:30 a.m., during a home	visit			

STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		H30189	B. WING	B. WING		04/06/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
ALTERN	ATIVE SENIOR CARE		I STREET S ENTRE, MN 56	6378			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
01035	Continued From pa	age 42	01035				
	(ULP)-C provide as stockings, bed mak	rved unlicensed personnel sist with donning compression king, laundry, opening blinds, e counter, and taking the					
	Treatment /Therapy June 14, 2022, indi therapy service liste was not on the curr Management Plan requirements: -written instructions -procedure to notify	s for the treatment, / the RN or other licensed when a problem arose with by, and ructions related to					
	Treatment/Therapy June 14, 2022, indi compression stock documentation and health record (EHR of the EHR; RN-As stockings in the EH that order would be	ings with specific I instruction on the electronic I). Evaluator requested review stated, "I only see compression IR; I assume it would be where and attached to, but I do not here. I don't know what					
	dated July 2019, in prescriber's order r treatment or medic provided to the clie would review all me for progress, effect	lication & Treatment Orders, dicated a current, written nust be maintained for any ation administration being nt and the licensed nurse edication and treatment orders iveness and necessity on a vith client change of condition;					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/06/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	STREET S NTRE, MN 56	5378		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 43	01035			
	development of an	did not give direction as to the individualized treatment and nt plan, as required.				
	No further informati	on was provided.				
	TIME PERIOD FOF days	R CORRECTION: Seven (7)				
01050 SS=E	144A.4793, Subd. 6 Orders	Treatment and Therapy	01050			
	prescriber for all tre order must contain description of the tr provided, and the fr information needed	ded order from an authorized atments and therapies. The the name of the client, a eatment or therapy to be equency, duration, and other to administer the treatment or and therapy orders must be				
	by: Based on observati review the licensee written or electronic prescription with all	ent is not met as evidenced on, interview and record failed to ensure an up-to-date cally recorded order or the required content, for all rapies was completed for two C3).				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a pat limited number of c	ed in a level two violation (a t harm a client's health or botential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than staff are involved, or the				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		TH STREET S CENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01050	Continued From pa	age 44	01050			
	situation has occur found to be pervasi	red repeatedly; but is not ive).				
	The findings include	e:				
	at 9:56 a.m., opera care manager (CCI (RN)-A stated the li	e conference on April 4, 2023 tions manager (OM)-E, clien M)-D, and registered nurse censee provided treatment gement services to their curre	t			
	C2 C2's diagnoses incl diabetes, and chror	luded muscle weakness, nic pain.				
	Modification To The 2020, indicated C2	dated July 24, 2018, and e Service Plan, dated July 23 received services including keeping, and medication medication set up.	i,			
	p.m., the surveyor of C2's medications a large, round shaped of the base of C2's had an appointmen of the previous wee to dressing the wou started on oral antil infection to the area	t on April 4, 2023, at 12:15 observed while RN-A set up nd completed wound care to d scabbed area on the outsid right great toe. C2 reported at at the wound clinic at the e ek, and there were no change und; however stated he was biotics for 10 days, due to a. RN-A removed the rolled	de he nd			
	needed to dampen the gauze from the area on the top of t a foot bathing devic he placed both feet several minutes, RI	bund C2's right foot and the gauze with water to loos scabbed area and an open he second toe. RN-A brough the filled with water to C2 and the water to soak. After N-A assisted C2 to remove h , dried his feet, sprayed the	t			

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building:			E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
ALTERN	ATIVE SENIOR CARE	. INC	I STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01050	wounds with a salin ointment to each ar Although the servic was performed by t stated she performed week when she set and his wife complet the week. C2's record lacked wound care being p On April 6, 2023, at as she knew, there wound care and that what someone told had left a message appointment last we call from them. C3 C3's diagnoses incl (increase fluid reter (inflammation of the kidney disease (gra C3's service plan da C3 received assista	e spray, applied an antibiotic ea, and applied bandages. e plan indicated wound care he RN twice weekly, RN-A ed the wound care once a up C2's medications, and C2 eted the wound care the rest of prescriber orders for the provided. 1:50 p.m., RN-A stated, as fail were no orders for C2's at she was "going along with me prior." RN-A stated she for the wound clinic after C2's eek, but had not received a uded bilateral leg edema ntion to both legs), pancreatitis e pancreas), and chronic idual loss of kidney function). ated June 14, 2022, indicated ance with support stocking, il cleaning, laundry, linen	r	DEFICIENCY	Y)	
	the surveyor observ (ULP)-C provide as stockings, bed mak	7:30 a.m., during a home visit ved unlicensed personnel sist with donning compression ing, laundry, opening blinds, counter, and taking the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/	06/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		'H STREET S CENTRE, MN 56	378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01050	Continued From pa	nge 46	01050			
	recorded prescription	written or electronically on for the compression Iministered treatment or				
		t 11:15 a.m., CCM-D stated rs for compression stockings				
	Treatment/Therapy June 14, 2022, indi compression stock documentation and health record (EHR review of the EHR; compression stock would be where that to but I do not have		d			
	dated July 2019, in prescriber's order r	lication & Treatment Orders, dicated a current, written nust be maintained for any ation administration being nt.				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01060 SS=F	144A.4794, Subd.	1(a) Client Record	01060			
	records for each cli services. Entries in current, legible, per	provider must maintain ient for whom it is providing the client records must be manently recorded, dated, with the name and title of the				

STATE FORM

If continuation sheet 47 of 55

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		H STREET S ENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	ige 47	01060			
	person making the	entry.				
	by: Based on interview licensee failed to er authenticated with t person making the (C2, C4, C1, C3). This practice result violation that did no safety but had the p client's health or sa cause serious injury is issued at a wides are pervasive or rej	ent is not met as evidenced and record review, the nsure the client record was the name and title of the entries for four of four clients ed in a level two violation (a ot harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and spread scope (when problems present a systemic failure that the potential to affect a large clients).	t			
	The findings include C2 C2's diagnoses incl diabetes, and chror	luded muscle weakness,				
	C2's Service Plan, Modification To The 2020, indicated C2	dated July 24, 2018, and Service Plan, dated July 23, received services including keeping, and medication				
	2022, November 8, December 13, 2022 January 3, 2023, ar an electronic signat previously worked f identified the nurse	ote, dated September 13, 2022, November 29, 2022, 2, December 20, 2022, nd January 10, 2023, included ture from an RN that for the licensee; however, as a "Personal Assistant." ote, dated January 24, 2023,				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		H30189	B. WING			00/0000
	PROVIDER OR SUPPLIER		ADDRESS, CITY, S		04/	06/2023
		418 10T	H STREET S	IAIL, ZIF CODE		
ALIERN	ATIVE SENIOR CARE	SAUK C	ENTRE, MN 5	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	age 48	01060			
	2023, March 14, 20 March 28, 2023, in (RN)-A's typewritte	, February 28, 2023, March 7, D23, March 21, 2023, and cluded registered nurse n name; however, lacked a tified RN-A as a "Personal				
	Ũ	luded muscle weakness, s, hearing issues, and history				
		dated April 30, 2021, indicated es including medication general cleaning.	t			
	2022, December 6 included an electro previously worked identified the nurse C4's Nurse Visit No March 14, 2023, M 2023, and April 4, 2 practical nurse (LP	ote, dated September 13, , 2022, and January 10, 2023, onic signature from an RN that for the licensee; however, e as a "Personal Assistant." ote, dated March 6, 2023, arch 21, 2023, March 28, 2023, included licensed N)-B typewritten name; signature and identified LPN-I istant."				
	humerus, bradycar	luded closed fracture left dista dia (slow heart rate), atrial al heart rate), and syncope out, passing out).	1			
	C1 received assistant administration, bat	dated July 16, 2021, indicated ance with medication hing assist, general cleaning, ge, companionship, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
01060	Continued From pa	age 49	01060			
	transportation.					
		ote dated, March 9, 2023, h credentials of a Personal				
	(increase fluid rete (inflammation of th	luded bilateral leg edema ntion to both legs), pancreatitis e pancreas), and chronic adual loss of kidney function).	3			
	C3 received assista	dated June 14, 2022, indicated ance with support stocking, al cleaning, laundry, linen anionship.				
		ote dated, March 2, 2023, n credentials of a Personal				
	manager (CCM)-D was the electronic the computer progr	t 3:35 p.m., client care stated the name on the form signature of the staff; however ram would not allow the staffs' <i>r</i> ing all staff as "personal	,			
	No further informat	ion was provided.				
	TIME PERIOD FO Twenty-One (21) d					
01080 SS=F	144A.4794, Subd.	3 Contents of Client Record	01080			
	for each client: (1) identifying inform	t record include the following mation, including the client's , address, and telephone				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		I STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01080	number; (2) the name, addrea an emergency cont representative, if ar (3) names, address the client's health a and other home can (4) health informatia allergies, and when medications, treatm documentation, and records; (5) client's advance (6) the home care p assessments and s (7) all records of co client's home care s (8) documentation of client's status and a the needs of the clin appropriate supervit professional; (9) documentation of and actions taken in client including repo supervisor or health (10) documentation provided as identified (11) documentation and reviewed the h (12) documentation provided the statem limitations of servic subdivision 3; (13) documentation resolution; (14) discharge sum	ess, and telephone number of act, family members, client's ny, or others as identified; ees, and telephone numbers of nd medical service providers re providers, if known; on, including medical history, the provider is managing nents or therapies that require d other relevant health edirectives, if any; provider's current and previous service plans; mmunications pertinent to the services; of significant changes in the actions taken in response to ent including reporting to the sor or health care of incidents involving the client in response to the needs of the orting to the appropriate in care professional; that services have been ed in the service plan; that the client has received ome care bill of rights; that the client has been nent of disclosure on es under section 144A.4791, of complaints received and mary, including service and related documentation,			, 	

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		H30189	B. WING		04/06/20	023
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	- INC	10TH STREET S K CENTRE, MN 5	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE CC	(X5) DMPLET DATE
01080	Continued From pa	age 51	01080			
		ntation required under this nt to the client's services of	r			
	by: Based on interview licensee failed to e included the require discharged client (This practice result violation that did no safety but had the client's health or sa cause serious injur is issued at a wides are pervasive or re	ent is not met as evidence and record review, the nsure the client record ed content for one of one C5). ted in a level two violation (ot harm a client's health or potential to have harmed a afety, but was not likely to ry, impairment, or death), a spread scope (when proble present a systemic failure to s the potential to affect a late	a nd ems			
	portion or all of the The findings includ					
	C5 was discharged on October 4, 2022	I from the home care provi 2.	der			
		eluded, dementia, type 2 od pressure, obesity, stroke	,			
	C5 received servic bathing, grooming, safety supervision,	dated May 9, 2022, indicat es including assistance wit dressing, continence care companionship, and ement including weekly	h			
		es dated September 16, 202 ily member called and state				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		STREET S NTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
01080	Continued From pa	ge 52	01080			
	facility because she	unit for C5 at a health care couldn't be at home , home care services would be				
	C5's record lacked required.	a discharge summary, as				
	(RN)-A stated C5's	: 2:15 p.m., registered nurse record did not include a y upon the client's discharge n't do that."				
	revised July 2, 2020	nt Record-Outline policy,), indicated client records harge summary and related				
	No further informati	ion was provided.				
	TIME PERIOD FOF Twenty-One (21) da					
01185 SS=D	144A.4796, Subd. 5 Training Required	5 Alzheimer's/Dementia	01185			
	persons with Alzhei direct care staff and those clients must r current explanation related disorders, e problem-solve whe challenging behavio	viders that provide services for mer's or related disorders, all d supervisors working with receive training that includes a of Alzheimer's disease and offective approaches to use to n working with a client's ors, and how to communicate ve Alzheimer's or related				
	This MN Requiremo	ent is not met as evidenced				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE	INC	H STREET S ENTRE, MN 56	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
01185	Continued From pa	age 53	01185			
	licensee failed to e disease and related	r and record review, the nsure training of Alzheimer's d disorders was provided for yees (registered nurse				
	violation that did no safety but had the client's health or sa cause serious injur was issued at an is limited number of s	ted in a level two violation (a bt harm a client's health or potential to have harmed a afety, but was not likely to y, impairment, or death), and colated scope (when one or a clients are affected or one or a staff are involved or the red only occasionally).	1			
	The findings includ	e:				
		a comprehensive home care ed services in the community				
	at 9:56 a.m., opera staff were provided which included den	e conference on April 4, 2023, tions manager (OM)-E stated orientation training upon hire nentia training, through an system and stated she would fon transcript.				
	RN-A had a hire da	te of January 2, 2023.				
	printed April 4, 202 a module titled "De Overview," comple 2022. OM-E provid included descriptio progression and tre	ecord included My Transcript, 3, at 1:23 p.m., which included mentia - Overview - ted by RN-A on December 31 ed the course overview which n of the facts, symptoms, eatments of Alzheimer's lacked evidence the employe	d , ,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H30189	B. WING		04/	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ALTERN	ATIVE SENIOR CARE		TH STREET S CENTRE, MN 50	6378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
01185	Continued From pa	ige 54	01185			
	working with clients and how to commu Alzheimer's disease On April 6, 2023, at completed all of the assigned to her and included the above On April 6, 2023, at ensured all staff red Disease related tra what RN-A had rec because her orients previous RN. OM-E did not include all o assigned to other s The licensee's Alzh Disorders - Alzheim Disorders - Alzheim Disorders - Training May 1, 2014, indicat to all home care sta current explanation related disorders, en problem-solve whe client behaviors, an with clients who har related disorders. No further informat	2:38 p.m., OM-E stated she ceived the required Alzheimer ining; however wasn't sure eived for dementia training ation was completed by the indicated RN-A's transcript of the modules that were taff. weimer's Disease and Related g and Notification policy, date ated the licensee would provide aff, training that included a of Alzheimer's Disease and effective approaches to use to n working with challenging and how to best communicate ve Alzheimer's Disease or	r's I de			