DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 6, 2023

Licensee
Belevo Health Services, LLC
4301 Welcome Avenue North
Crystal, MN 55422

RE: Project Number(s) SL34395015

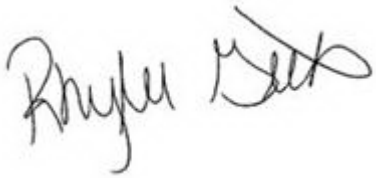
Dear Licensee:

On April 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 24, 2023, facility were corrected. This follow-up survey verified that the facility is in substantial 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,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

JMD

Electronically Delivered

March 6, 2023

Licensee
Belevo Health Services,LLC
4301 Welcome Avenue North
Crystal, MN 55422

RE: Project Number(s) SL34395015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1020 - 144g.52 Subd. 5 - Expedited Termination - $3,000.00
St - 0 - 1040 - 144g.52 Subd. 7 - Notice Of Contract Termination Required - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $12,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please email 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:

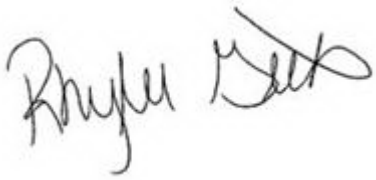
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Rhylee Gilb, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: rhylee.gilb@state.mn.us
Phone: 651-201-5977 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34395	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELEVO HEALTH SERVICES,LLC	4301 WELCOME AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: ***REVISED*** SL34395015 On January 23, 2023 and January 24, 2023, the Minnesota Department of Health conducted a CHOW survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents receiving services under the provider's Assisted Living license. The following correction orders are issued. The following immediate correction order, tag identification 2070 immediacy was removed on January 23, 2023. The tag remains issued at a level F.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two current residents (R1, R2) with records reviewed received a copy of the licensee's Uniform Disclosure of Assisted Living Services Available (UDALSA). In addition, the licensee failed to ensure the UDALSA was updated and accurate, which had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 430		

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0 430	Continued From page 2 Findings Include: The licensee's UDALSA dated April 6, 2022, page 2, indicated licensed staff were onsite 24/7 (24 hours per day, seven days per week). In addition, the UDALSA indicated two unlicensed personnel (ULP) worked the day shift. On January 23, 2023, at 9:35 a.m., the Minnesota Department of Health (MDH) surveyors observed the January 2023 staff schedule on a bulletin board that was placed on the sofa. The January 2023 schedule indicated there was only one ULP scheduled for the day shift, from 7:00 a.m. to 3:00 p.m. During the entrance conference on January 23, 2023, at 11:04 a.m., registered nurse (RN)-B stated she was the only RN for the licensee's two facilities. RN-B stated she usually worked from home on Mondays but stated she worked 9:00 a.m. until 2:00 p.m., two to three days per week. R1 R1's medical record was reviewed. R1 admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a change of ownership (CHOW). R1's diagnoses included anxiety, mood disorder, head injury, and suicidal ideation's. R1's service plan dated August 15, 2022, indicated R1 received assistance with personal cares, medication management, wandering, fall risks, behaviors, post-traumatic stress syndrome (PTSD), and finances. R1 used a wheeled walker for mobility. R1's record lacked an acknowledgement of	0 430		

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0 430	Continued From page 3 receipt of a UDALSA signed by the resident or representative. R2 R2's medical record was reviewed. R2 admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a CHOW. R2's diagnoses included type 2 diabetes mellitus, high cholesterol, obsessive-compulsive disorder, schizoaffective bipolar, and narcissistic personality disorder. R2 walked independently. R2's service plan dated August 12, 202, indicated R2 received assistance with personal cares, medication management, appointments, behaviors, schizoaffective disorder, meals, laundry, housekeeping, and socialization. R2's record lacked an acknowledgement of receipt of a UDALSA signed by the resident or representative. On January 25, 2023, at 1:48 p.m., OW-C confirmed the licensee's UDALSA was outdated. The license policy titled Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), dated August 1, 2021, indicated the licensee would provide a UDALSA to prospective residents prior to signing an assisted living contract. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 430		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week;	0 460		

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0 460	Continued From page 4 (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a reliable means for residents to request staff assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all the residents (R1, R2) who resided at the licensee's facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On January 23 through 25, 2023, the Minnesota	0 460		

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0 460	Continued From page 5 Department of Health (MDH) conducted an onsite change of ownership (CHOW) survey. The facility was a structure that contained four resident rooms, two on the main floor and two resident rooms on the basement level. R1's room was located on the main level and R2 resided on the basement level. R1's service plan dated August 15, 2022, indicated R1 received services for diagnoses that included hypertension, Wallenberg's stroke syndrome, neuropathy of the lower limbs, sleep apnea, major neurocognitive disorder secondary to a traumatic brain injury, and ataxia. R1's progress note dated December 9, 2022, at 5:00 p.m., documented by registered nurse (RN)-B, indicated R1 told RN-B he fell off his bed. RN-B's note indicated the fall was unwitnessed and R1's memory, "is declining and fear of falling is increasing". R1's progress note dated December 10, 2022, at 6:36 a.m., documented by unlicensed personnel (ULP), indicated R1 had three falls during the night shift, at 1:40 a.m., 3:20 a.m., and 3:40 a.m. R1's note indicated the following: -1:40 a.m.: ULP heard a "loud noise" coming from R1's room and R1 had fallen to the floor. ULP helped him get back into bed. -3:20 a.m.: ULP heard "another very loud sound". R1 had fallen to the floor and ULP helped get him into bed. -3:40 a.m.: R1 went to the restroom, returned to his room, and slipped off of his bed. R1 required assistance getting his underclothing back on. R1's progress note dated December 27, 2022, at 1:00 p.m., documented by RN-B, indicated R1 fell and "is sick". In addition, the note indicated R1	0 460		

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0 460	Continued From page 6 had a "near fall" at 1:45 p.m. On January 23, 2023, at 1:45 p.m., R1 stated if he needed assistance he yelled for staff. R1 confirmed he did not have a call pendant or call light to press or pull if he required assistance from staff. On January 25, 2022, at 2:00 p.m., RN-B and OW-C acknowledged the licensee lacked a call system. A policy was not provided Time period for correction 21 days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached	0 470		

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0 470	Continued From page 7 building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required, potentially affecting all of the current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Minnesota (MN) Rules, part 4659.0180, subpart (subp) 4, item A, subitem (1) (2), and item B, indicated the clinical nurse supervisor (CNS) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct care staff work schedules for each direct care staff member showing all work shifts, including days and hours worked; (2) identify the direct care staff member's resident assignments or work location. The daily work schedule in item A must be posted, after redacting direct-care staff members' resident's	0 470		

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0 470	Continued From page 8 assignments, at the beginning of each work shift in a central location in each building or a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose information that is protected by law from public disclosure. The licensee was licensed on April 11, 2022, after it acquired the assisted living facility in a change of ownership (CHOW). The facility was licensed for a bed capacity of four (4) residents and had a current census of two residents (R1, R2). On January 23, 2023, at 9:05 a.m., the state surveyors entered the facility. At 9:30 a.m., the surveyors observed the January 2023 staff schedule posted on the facility's board. During the entrance conference on January 23, 2023, at 11:04 a.m., registered nurse (RN)-B stated she annually and bi-weekly reviewed the facility's staffing plan. RN-B stated shift times were 7:00 a.m.-3:00 p.m.(morning); 3:00 p.m.-11:00 p.m. (evening), and 11:00 p.m.-7:00 a.m.(overnight). RN-B stated one unlicesed personnel (ULP) worked per shift. Owner (OW)-C stated on January 24, 2023, they were possibly going to admit a new resident, but stated that might not happen because of the survey. The state surveyors asked OW-C to see their staffing plan. OW-C produced a staff schedule dated November 27, 2022 through December 31, 2022. OW-C stated the online copies of their schedule/staffing plan would not accurately reflect the facility's staffing per shift, stating it would look as though they had no staff on during certain shifts, stating the paper copies were more accurate. The state surveyors asked to see the paper copies. OW-C stated she would	0 470		

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0 470	Continued From page 9 have to go find them in the office. OW-C provided staff schedules but did not provide a staffing plan. Review of the staff schedules dated November 27, 2022 through December 31, 2022, indicated the facility did not have a ULP scheduled for the following days/shifts: 11.28.22-evening shift 11.29.22-morning, evening shifts 11.30.22-morning, evening shifts 12.1.22-evening, overnight shifts 12.2.22-evening shift 12.5.22-12-9.22-morning, evening shifts 12.12.22-12.16.22-morning, evening shifts 12.19.22-morning shift 12.20.22-evening shift 12.21.22-12.22.22-morning, evening, overnight shifts 12.23.22-morning shift 12.26.22-only two shifts 7:00 a.m.-6:00 p.m. and 6:00 p.m.-7:00 a.m. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 480		

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	34395	A. BUILDING: _____ B. WING _____	01/24/2023

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0 480	Continued From page 10 review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated Jaunuary 23, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a	0 485		

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0 485	Continued From page 11 food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On January 23, 2023, at 9:05 a.m., the Minnesota Department of Health (MDH) surveyors entered the facility On January 23, 2023, at 10:22 a.m., the surveyors observed a whiteboard meal menu hanging on the refrigerator door. The menu listed the days Sunday through Saturday, with areas to fill in the day's meals. The MDH surveyors observed the following meals were listed on corresponding dates: 1.22.23 (Sunday): Egg/biscuit sausage; din-chicken strip/corn 1.23.23 (Monday): Barbeque sauce, chicken strip/vegetable	0 485		

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0 485	Continued From page 12 1.24.23 (Tuesday): Pork ribs-country, mashed, corn. (mashed potatoes) 1.25.23 (Wednesday): Chill & crackers. 1.26.23 (Thursday): Rice, chicken legs. 1.27.23 (Friday): Pizza; 1.28.23 (Saturday): No meal listed. The facility's meal menu lacked evidence it served three meals per day for its residents. On January 23, 2023, at 10:22 a.m., unlicensed personnel (ULP)-A stated she was in charge of planning and completing the resident's food menu. The licensee policy titled Food Service and Menu Planning, dated August 1, 2021, indicated menus would be prepared one week in advance and made available to all residents. The licensee would provide three meals per day according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and vegetables. TIME PERIOD TO CORRECT: Twenty-one days.	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide	0 490		

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0 490	Continued From page 13 reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On January 23, 2023, at 9:05 a.m., the Minnesota Department of Health (MDH) surveyors entered the facility. The surveyors observed a calendar titled, "Cleaning Schedule". The calendar lacked dates, only displayed days Monday through Sunday. The calendar identified cleaning tasks during each shift. Mixed in with the staff's	0 490		

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0 490	Continued From page 14 cleaning schedule were the following listed resident actvities: *Tuesday pm shift: Go to the movies *Thursday pm shift: Game night In-house *Saturday: Go out for coffee During an interview with R1 on January 23, 2023, at 2:20 p.m., R1 said he would like to go to the library to get reading materials. During the entrance conference on January 23, 2023, at 11:04 a.m., owner (OW)-C stated the staff"s calendar cleaning schedule was also used as the resident's activity calendar. OW-C acknowledged the lack of scheduled daily activities and stated the facility was planning to expand their resident activity schedule. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 15 by: Based on interview and record review, the licensee failed to ensure an Individual Abuse Prevention Plan (IAPP) was updated after R3's self-injurous behavior. R3 jumped off his family member's second floor balcony during a weekend visit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: R3's medical record was reviewed. R3 admitted to the facility on November 30, 2021 during the time the previous licensee owned the facility. R3's diagnoses included diffuse traumatic brain injury (TBI) with unspecified loss of consciousness, major neurocognitive disorder due to TBI, antisocial traits, and borderline intellectual functioning. R3's service plan dated November 30, 2021, indicated R3 received assistance with personal cares, behaviors, verbal aggression, hallucinations, delusions, paranoia, scheduling appointments, and protection of self-preservation. R3 was not able to be alone in the community due to mental health symptoms and cognitive abilities. R3 walked independently. R3's IAPP dated November 30, 2021, indicated R3 was susceptible to abuse in the following areas: R3 had a history of alcohol and illegal drug	0 630		

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0 630	Continued From page 16	0 630		

use (methamphetamine, cannabis use). R3 stated he used illegal drugs and alcohol for six months. Interventions included staff were to report any signs of R3 being under the influence of drugs/alcohol to management. Staff were to follow R3's behavior plan. R3 did not recognize or protect self against potentially abusive/harmful situations. R3 had a history of self-abuse that included opioid overdose and suicide attempt. Staff were to follow R3's behavior plan and would report any changes in condition or signs of self-abuse. R3 had the following behaviors: intentionally ran away from group, lying, false accusations, verbal aggression, destroyed property, substance abuse, and impaired judgement when he abused alcohol or used illicit drugs. Line 15, page five indicated R3 was susceptible to being abused by other adults, including other vulnerable adults. Staff were to follow R3's behavior plan. The facility implemented no community alone time for 45 days then afterwards would receive four hours alone time.

The facility did not provide R3's behavior plan.

The licensee was licensed on April 11, 2022, after it acquired the assisted living facility in a change of ownership (CHOW).

R3's progress note dated June 20, 2022, at 12:52 p.m., a registered nurse (RN) received a phone call from a local hospital indicating R3 admitted to the hospital for one week after he jumped off his mother's second floor balcony. R3 suffered a spinal fractures in his low back and ankle.

R3's progress note dated June 22, 2022, at 1:16 p.m., indicated R3 returned to the facility after he was discharged from the hospital.

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0 630	Continued From page 17 R3's IAPP was not updated to include new interventions after R3 jumped from his mother's second floor. On January 23, 2023, at 11:04 a.m., RN-B stated she redid the resident's nursing assessments after the licensee acquired the facility, stating, "I pretty much restarted everything." The licensee policy titled Individual Abuse Prevention Plan, dated August 1, 2021, indicated the licensee would develop and implement an IAPP for each vulnerable adult. All residents in the assisted living facility were considered vulnerable adults. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure history, symptoms, tuberculosis (TB) risk assessment screening were completed and documented for one of two unlicensed personnel (ULP-E) with record reviewed. In addition, ULP-E's employee record did not include her Quantiferon TB test result. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired September 24, 2020 prior to the licensee's change of ownership (CHOW). ULP-E's employee record contained a document titled, Minnesota Comprehensive Home Care License for Assisted Living-Orientation Checklist Requirements. Beneath the title was a line for ULP-E's Mantoux date that read, "Quant: 10/20/2020. A hand written note in ULP-E's record, written by ULP-E, date illegible, stated, "I'm here to asked to please release my TB test result." ULP-E employee record lacked evidence she completed a TB history and annual symptoms screening. In addition, her record lacked evidence of the results of her Quantiferon TB blood test.	0 660		

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0 660	Continued From page 19 On January 23, 2023, at 11:20 a.m., owner (OW)-C and registered nurse (RN)-B stated they were familiar with current assisted living laws and regulations. A TB policy was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a tour on January 23, 2022, at 10:00 a.m., surveyors observed the licensee lacked posted emergency exit diagrams on each floor. Licensee's emergency preparedness plan, dated 2021, lacked the following required content: - a description of the population served by the licensee. - specific roles in another's absence - process for EP collaboration with federal EP officials - policies and procedures for volunteers - roles under a waiver declared by secretary - development of a communication plan - emergency officials contact information including federal, tribal, MN office of ombudsman for LTC and state licensing and certification agency. - annual EP training	0 680		

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0 680	Continued From page 21 - EP testing requirements - integrated health systems Licensee's EP plan, dated 2021, indicated the facility risk assessment would be completed August 1 of each year. During an interview with registered nurse (RN)-B and owner (OW)-C on January 25, 2023, at 11:05 a.m., RN-B and OW-C confirmed EP plan dated 2021 was their most updated plan. The licensee policy titled, Disaster Planning and Emergency Preparedness, dated August 1, 2021, indicated the licensee would have a written emergency disaster plan that contained a plan that incorporated all Appendix Z requirements. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730		

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0 730	Continued From page 22 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure accurate resident information and documentation were part of the resident record for two of two current residents (R1, R2), and one former resident (R3) with records reviewed. R1 and R2's progress notes record contained multiple random staff	0 730		

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0 730	Continued From page 23 conversations, and facility related issues. R1 and R2's record also contained each other's information in their records. In addition, R3's record lacked a discharge summary. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During entrance conference on January 23, 2023, at 11:04 a.m., the surveyors requested resident records, including progress notes. On January 25, 2023, at 12:15 p.m., owner (OW)-C provided surveyors R1's progress notes. R1 R1's medical record was reviewed. R1 admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a change of ownership (CHOW). R1's diagnoses included anxiety, mood disorder, head injury, and suicidal ideation's. R1's service plan dated August 15, 2022, indicated R1 received assistance with personal cares, medication management, wandering, fall risks, behaviors, post-traumatic stress syndrome (PTSD), and finances. R1 used a wheeled walker for mobility. R1's progress notes dated October 2022 through January 2023, contained 37 pages of notes	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34395	A. BUILDING: _____ B. WING _____	01/24/2023

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0 730	Continued From page 24 printed from staff's Microsoft TEAM notes. Mixed in with R1's progress notes were photos of a facility maintenance request, the facility front entrance, garbage schedule, cleaning schedule, welcome message to newly hired unlicensed personnel (ULP)-A, and the following notes: 10/2/22, at 11:19 a.m. "Waiting on Nurse to set up Oct. MAR". 10/2/22, at 11:19 a.m. "figured that was it, thanks!" 10/2/22, at 11:21 a.m. "Yw. Also the credit card is in desk drawer. The guys want to go see a movie today". 10/2/22, 2022, at 11:28 a.m."I just asked (R1) which movie he wanted to see and he said he's watching the Vikings game today". 10//27/22, at 3:00 p.m. "Client woke up around 9 am asked for his medication ..." "Staff swept and mopped bathroom downstairs as well as disinfected counters and tub walls and took trash. Actual tub still needs to be scrubbed". 10/27/22, at 3:44 a.m. "(R1) was clipping his toenails and cut himself ..." next entry was at 4:27 p.m., "new door code at crystal". Next entry was at 10:30 p.m., "(number of code) new door code at crystal: 11/5/22, at 7:20 a.m. "Client was a little frustrated with new radio that he bought and asked for help setting it up ..." , 11/6/2022, at 2:46 a.m. "Can someone take my shift for Sunday night ..." In addition, R1's progress note dated November 13, 2022, at 10:38 p.m., contained R2's information: "after R2 went to work. Came home at 8:30 said he wasn't eating ate dinner with his brother. Took his (R2) meds after went downstairs to his room never came upstairs. Later staff went to check on him he was	0 730		

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0 730	Continued From page 25 sleeping." R2 R2's medical record was reviewed. R2 admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a CHOW. R2's diagnoses included type 2 diabetes mellitus, high cholesterol, obsessive-compulsive disorder, schizoaffective bipolar, and narcissistic personality disorder. R2 walked independently. R2's service plan dated August 12, 202, indicated R2 received assistance with personal cares, medication management, appointments, behaviors, schizoaffective disorder, meals, laundry, housekeeping, and socialization. R2's progress notes dated October 2022 through January 2023, contained 52 pages of notes printed from staff's Microsoft TEAM notes. Similar to R1, R2's progress notes contained R2's information as well as random staff member notes sent to all staff members. Some of R2's progress notes included notes regarding garbage duty, photos of a utility truck next to a telephone pole, torn boxes, meal bins, maintenance request, cleaning schedule, and the following notes: 10/24/22, at 7:31 a.m.: "Please remember to bring garbage down to the curb at Crystal on SUNDAY nights. Garbage gets picked up on Monday mornings." 10/27/22, at 4:27 p.m.: "new door code at crystal. Which door?" 11/3/22, at 4:59 p.m.: "Looks like I found it I'll give Xcel a call." 11/3/22, at 5:15 p.m.: "Don't open the fridge." 11/6/22, at 2:46 a.m.: "Can someone take my shift for Sunday night. Helping my sister move	0 730		

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0 730	Continued From page 26 this weekend don't know how I will fare tomorrow. Plz let me know. Also willing to exchange for another weekend shift or weekend shift, thank you!" 12/31/22, at 4:49 p.m.: "internet not working." 1/2/23, at 5:29 p.m.: "Has anyone seen the company phone and charger?" In addition, R2's note dated 11/15/22, at 11:00 p.m., contained R1's progress note: "R1 was awake watching TV on his bed he watched for quite some time had a smoke break, ate dinner burger and fried. Watched news in living room received medication, put on CPAP before sleep." R3 R3's medical record was reviewed. R3 admitted to the facility on November 30, 2021. R3's diagnoses included diffuse traumatic brain injury (TBI) with unspecified loss of consciousness, major neurocognitive disorder due to TBI, antisocial traits, and borderline intellectual functioning. R3's service plan dated November 20, 2021, indicated R3 received assistance with personal cares, behaviors, verbal aggression, hallucinations, delusions, paranoia, scheduling appointments, and protection of self-preservation. R3 was not able to be alone in the community due to mental health symptoms and cognitive abilities. R3 walked independently. R3's record indicated on June 20, 2022, registered nurse (RN)-B sent a letter to R3 indicating a proposed move-out and termination of R3's assisted living contract and housing, effective July 4, 2022. The letter indicated R3 was requested to move out within 15 days of receipt of the letter due to the following: exhibiting	0 730		

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0 730	Continued From page 27 behaviors that were an immediate danger to self or others, non-compliant in took medications away from the facility, and posed risk to staff-punched a female staff member in the face. An email dated June 21, 2022, at 1:27 p.m., from the facility's previous program manager to R3's case manager, indicated the facility was terminating services for R3. R3 was hospitalized at the time the email was sent after jumping off a second story balcony at a family member's house while on a weekend visit. R3's record lacked documentation a discharge summary was completed. On January 23, 2023, at 11:04 a.m., owner (OW)-C stated staff used Microsoft 365 (TEAMS) to document resident progress notes. Licensee's policy titled, Resident Record, dated August 1, 2021, indicated the licensee would maintain appropriate and accurate records for each resident received assisted living services. In addition, no personal, financial, medical or other information about the resident would be disclosed to any other person. The licensee policy titled, Contract Termination, dated August 1, 2021, indicated when a resident's contract was terminated the licensee would provide the resident, and with the resident's consent, the resident's representatives and case manager, with a written discharge summary that included: a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; a final summary of the resident's status from the latest assessment; a reconciliation of all pre-discharge	0 730		

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0 730	Continued From page 28 medications with the resident's post-discharge prescribed and over-the-counter medications, and a post-discharge care plan indicating where the resident plans to reside, and any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services the resident would need. TIME PERIOD TO CORRECT: Seven (7) days.	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms immediately outside areas used for sleeping. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 24, 2023, between 12:45 p.m. and 1:45 p.m., survey staff toured the facility with the owner (OW)-C. During the facility tour, survey staff observed there was no smoke alarm installed in the basement common area. The common area was immediately outside the basement bedrooms and required to have a smoke alarm per statute. The smoke alarm in the upstairs hallway was mounted more than 12" below the ceiling. OW-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 24, 2023, from approximately 12:45 p.m. to 1:45 p.m., survey staff toured the facility with the owner (OW)-C. During the facility tour, survey staff observed the following maintenance concerns: The transition strip in the basement common area between the laundry area and the living room	0 800		

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0 800	Continued From page 31 area was missing on the two sides of the corner and there was a loose tile in the corner. Residents could cut their feet or trip over the uneven flooring condition. Basement bedrooms #1 and #2 had egress windows that were obstructed by dead leaves built up in the window well. Windows opened approximately halfway when tested. The window hardware in bedroom #1 was difficult to use. The knob appeared to be partially stripped and did not efficiently open the window. There was no resident living in bedroom #1 at the time of the survey. Egress windows shall be maintained properly and window wells for egress windows shall be kept free of obstruction. OW-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 32 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 810		

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0 810	Continued From page 33 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on January 24, 2023, at 1:45 p.m., the owner (OW)-C stated they were doing staff training upon hire and one time per year after that. This does not comply with the training requirements in the statute. OW-C stated they had not done the required number of evacuation drills since taking ownership of the business. Review of the fire policy showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. The policy included R.A.C.E. and P.A.S.S. techniques but was not specific to the facility or staff. 2. No record of required employee evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 34 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect the licensee's two current residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 23, 2023, at 9:05 a.m., the Minnesota Department of Health (MDH) surveyors entered the facility. During the entrance conference on January 23, 2023, at 11:04 a.m., owner (OW)-C stated there were two residents who currently resided in the licensee's facility (R1, R2). R1's assisted living contract and lease agreement dated July 15, 2022, indicated as follows: "You agree that Landlord is not responsible for	0 970		

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0 970	Continued From page 35 any loss or damage to your personal property due to theft." During an interview with OW-C on January 25, 2023, at 1:48 p.m., OW-C acknowledged waiver was present on assisted living contract. Time period for correction 21 days.	0 970		
01020 SS=G	144G.52 Subd. 5 Expedited termination (a) A facility may initiate an expedited termination of housing or services if: (1) the resident has engaged in conduct that substantially interferes with the rights, health, or safety of other residents; (2) the resident has engaged in conduct that substantially and intentionally interferes with the safety or physical health of facility staff; or (3) the resident has committed an act listed in section 504B.171 that substantially interferes with the rights, health, or safety of other residents. (b) A facility may initiate an expedited termination of services if: (1) the resident has engaged in conduct that substantially interferes with the resident's health or safety; (2) the resident's assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the uniform checklist; or (3) extraordinary circumstances exist, causing the facility to be unable to provide the resident with the services disclosed in the uniform checklist that are necessary to meet the resident's needs. This MN Requirement is not met as evidenced by:	01020		

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01020	Continued From page 36 Based on interview and record review, the licensee initiated an expedited termination of the licensee's assisted living contract without having sufficient evidence of reason for one former resident (R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R3's medical record was reviewed. R3 admitted to the facility on November 30, 2021 during the time the previous licensee owned the facility. R3's diagnoses included diffuse traumatic brain injury (TBI) with unspecified loss of consciousness, major neurocognitive disorder due to TBI, antisocial traits, and borderline intellectual functioning. R3's service plan dated November 30, 2021, indicated R3 received assistance with personal cares, behaviors, verbal aggression, hallucinations, delusions, paranoia, scheduling appointments, and protection of self-preservation. R3 was not able to be alone in the community due to mental health symptoms and cognitive abilities. R3 walked independently. R3's individual abuse prevention plan (IAPP) dated November 30, 2021, indicated R3 was susceptible to abuse in the following areas: use of illegal drugs and alcohol abuse. Interventions	01020		

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BELEVO HEALTH SERVICES,LLC	4301 WELCOME AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01020	Continued From page 37 included staff were to report any signs of R3 being under the influence of drugs/alcohol to management. Staff were to follow R3's behavior plan. R3 did not recognize or protect self against potentially abusive/harmful situations. R3 had a history of self-abuse that included opioid overdose and suicide attempt. Staff were to follow R3's behavior plan and would report any changes in condition or signs of self-abuse. R3 had the following behaviors: intentionally ran away from group, lying, false accusations, verbal aggression, destroyed property, substance abuse, and impaired judgement when he abused alcohol or used illicit drugs. Line 15, page five indicated R3 was susceptible to being abused by other adults, including other vulnerable adults. Staff were to follow R3's behavior plan. The facility did not provide R3's behavior plan. R3's 51 pages of progress notes dated April 1, 2022, through June 20, 2022, indicated staff documented there were "no concerns," and "everything went well no concerns," except for the following incidents: -4/13/22, at 8:32 a.m. R3 went outside to smoke. R 3 attempted to go back inside the facility but the door was locked. R3 yelled and screamed after he was let inside. -5/10/ 2022, at 4:03 p.m. R3 refused to come upstairs after staff asked him multiple times to take his medications. Staff went to R3's room downstairs and noticed it was unlocked. Staff knocked then entered R3's room. R3 ran after staff and slammed his door shut, punching it twice after it was closed. After the incident R3 had a seizure. Staff called 911 but R3 declined to go to the hospital. Staff documented, "R3 seems so much better than he was this morning no other concerns at this time."	01020		

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01020	Continued From page 38 -5/30/22, at 10:46 p.m. R3 refused to close the bathroom door while he urinated. Program manager called. -6/20/22, at 12:52 p.m. R3 admitted to a hospital for self-injurious behavior. R3 jumped off his mother's second floor balcony during a visit. R3 sustained fractures in his low back and ankle. R3's record indicated a letter dated June 20, 2022, and written by registered nurse (RN)-B, indicated a proposed move-out and termination of R3's assisted living contract and housing, effective July 4, 2022. The letter indicated R3 was requested to move out within 15 days of receipt of the letter due to the following: exhibiting behaviors that were an immediate danger to self or others, non-compliant with taking medications while away from the facility, and "posed risk to staff due to R3 punched a female staff member in the face." R3's record did not include staff violence prior to June 20, 2022 and only one documented refusal to take his medication. R3's record lacked evidence R3 seriously interfered with other's rights and safety for an expedited termination. An email dated June 21, 2022, at 1:27 p.m., from the facility's previous program manager to R3's case manager, indicated the facility was terminating services for R3. R3 was hospitalized at the time the email was sent after he jumped off his mother's second story balcony. R3's progress notes dated June 21, 2022 through July 4, 2023, included the following incidents: -6/30/22, at 3:44 p.m. R3 was verbally abusive to staff after he did not get pain medication. R3 told staff to "get the fuck away from his door and to leave him alone."	01020		

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01020	Continued From page 39 -7/1/22, at 11:18 p.m. R3 asked staff to give him some water so he could take his medications. When staff told him to say "please" R3 "cussed" at staff. R3 insulted the program manager but then later apologized. -7/4/22, at 4:11 a.m. Staff asked R3 to keep the noise down in his room after he banged on something. At 4:05 a.m., R3 turned the outside light off when he went outside to smoke. When staff asked him to keep the light on, R3 responded, "fuck you, keep the light off bitch." R3 broke the lightbulb and proceeded to call the staff person a "ugly bitch" and slammed the door. R3 remained in his room the rest of the morning and was asleep when the overnight staff left her shift. A facility incident report dated July 2, 2022 through July 4, 2022, completed by owner (OW)-C, documented the following: "R3 observed cursing and yelling at staff during the morning of 7/1/22. Reported to OW-C on 7/2/22 that maintenance worker witnessed R3 call staff "bitch" several times while screaming, requesting narcotics and 1:1 service. Staff did not feel safe with his behaviors and tried "low and slow" approaches to deescalate him. Below the incident, OW-C documented a description of the action taken, "registered nurse (RN) continued to monitor medication and pain levels for R3. He was informed that his behavior will not be allowed at the facility and further issues will result in termination of services." R3's progress note dated July 4, 2022, at 2:00 p.m., written by the licensee's former program manager, documented, "R3 move out day. R3 was discharged after physically assaulting a female staff. R3 was taken to the hospital and will be discharged from the facility to his mother's house."	01020		

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01020	Continued From page 40 R3's termination notice letter referenced the incidents that occurred between July 1, 2022 through July 4, 2023, however was dated prior to the incidents occurring on June 20, 2022. Furthermore, R3 was moved out of the facility the same day OW-C completed an incident report regarding the incidents. On January 23, 2023, at 9:50 p.m., in an email sent to the state surveyor, the OOLTC indicated their office never received a notice from the facility regarding R3's expedited termination of housing and services. The email indicated the facility responded indicating R3 caused quite a bit of damage to the facility and other issues. OOLTC's email indicated the facility was informed they were not following legal process per statute. R3's record lacked documentation he damaged the licensee's property. On January 25, 2023, at 11:25 a.m., RN-B stated, "we pushed for a termination process. Until we were licensed we couldn't do anything. We didn't want it to fall apart." The licensee policy titled, Contract Termination, dated August 1, 2021, indicated the licensee would follow proper procedures, for terminating an assisted living contract with a resident. TIME PERIOD TO CORRECT: Seven (7) days.	01020		
01040 SS=G	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this	01040		

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01040	Continued From page 41 section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice of an expedited termination of contract to the Office of Ombudsman for Long Term Care (OOLTC) and failed to give adequate notice of 15 days for one former resident (R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01040		

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01040	Continued From page 42 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's medical record was reviewed. R3 admitted to the facility on November 30, 2021 during the time the previous licensee owned the facility. R3's diagnoses included diffuse traumatic brain injury (TBI) with unspecified loss of consciousness, major neurocognitive disorder due to TBI, antisocial traits, and borderline intellectual functioning. R3's service plan dated November 30, 2021, indicated R3 received assistance with personal cares, behaviors, verbal aggression, hallucinations, delusions, paranoia, scheduling appointments, and protection of self-preservation. R3 was not able to be alone in the community due to mental health symptoms and cognitive abilities. R3 walked independently. R3's individual abuse prevention plan (IAPP) dated November 30, 2021, indicated R3 was susceptible to abuse in the following areas: use of illegal drugs and alcohol abuse. Interventions included staff were to report any signs of R3 being under the influence of drugs/alcohol to management. Staff were to follow R3's behavior plan. R3 did not recognize or protect self against potentially abusive/harmful situations. R3 had a history of self-abuse that included opioid overdose and suicide attempt. Staff were to follow R3's behavior plan and would report any changes in condition or signs of self-abuse. R3 had the	01040		

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01040	Continued From page 43	01040		

following behaviors: intentionally ran away from group, lying, false accusations, verbal aggression, destroyed property, substance abuse, and impaired judgement when he abused alcohol or used illicit drugs. Line 15, page five indicated R3 was susceptible to being abused by other adults, including other vulnerable adults. Staff were to follow R3's behavior plan.

The facility did not provide R3's behavior plan.

R3's record indicated a letter dated June 20, 2022, and written by registered nurse (RN)-B, indicated a proposed move-out and termination of R3's assisted living contract and housing, effective July 4, 2022. The letter indicated R3 was requested to move out within 15 days of receipt of the letter due to the following: exhibiting behaviors that were an immediate danger to self or others, non-compliant with taking medications while away from the facility, and "posed risk to staff due to R3 punched a female staff member in the face."

R3's 51 pages of progress notes dated April 1, 2022, through June 20, 2022, did not include staff violence prior to June 20, 2022 and only one documented refusal to take his medication.

An email dated June 21, 2022, at 1:27 p.m., from the facility's previous program manager to R3's case manager, indicated the facility was terminating services for R3. R3 was hospitalized at the time the email was sent after he jumped off his mother's second story balcony.

A facility incident report dated July 2, 2022 through July 4, 2022, completed by owner (OW)-C, documented the following: "R3 observed cursing and yelling at staff during the morning of

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01040	Continued From page 44 7/1/22. Reported to OW-C on 7/2/22 that maintenance worker witnessed R3 call staff "bitch" several times while screamng, requesting narcotics and 1:1 service. Staff did not feel safe with his behaviors and tried "low and slow" approaches to deescalate him. Below the incident, OW-C documented a description of the action taken, "registered nurse (RN) continued to monitor medication and pain levels for R3. He was informed that his behavior will not be allowed at the facility and further issues will result in termination of services." R3's progress note dated July 4, 2022, at 2:00 p.m., written by the licensee's former program manager, documented, "R3 move out day. R3 was discharged after physically assaulting a female staff. R3 was taken to the hospital and will be discharged from the facility to his mother's house." R3's termination notice letter referenced the incidents that occurred between July 1, 2022 through July 4, 2022, however was dated prior to the incidents occuring on June 20, 2022. Furthermore, R3 was moved out of the facility the same day OW-C completed an incident report regarding the incidents. Therefore, R3 was not issued an expedited termination notices of 15 days prior to the incident(s) that initiated the expeditated termination between July2 and July4, 2022. On January 23, 2023, at 7:07 p.m., an email was sent to OOLTC asking if the OOLTC received a notice from the facility regarding R3's expedited termination from the facility. On January 23, 2023, at 9:50 p.m., OOLTC emailed the surveyor indicating OOLTC never	01040		

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01040	Continued From page 45 received a notice from the facility. The email indicated the facility responded indicating R3 caused quite a bit of damage to the facility and other issues. OOLTC's email indicated the facility was informed they were not following legal process per statute. On January 23, 2023, at 11:04 a.m., OW-C and RN-B stated they were familiar with current assisted living laws and regulations, (144G.82, Subd. 3). The licensee policy titled, Contract Termination, dated August 1, 2021, indicated the licensee would follow proper procedures, for terminating an assisted living contract with a resident. TIME PERIOD TO CORRECT: Seven (7) days.	01040		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370		

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01370	Continued From page 46 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency was completed to include all required content for one of two unlicensed personnel (ULP-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01370		

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01370	Continued From page 47 ULP-A was hired on December 17, 2022. ULP-A's employee competency checklist dated December 28, 2022, indicated areas of training ULP-A received. The form fails to identify required evaluation for core competencies. ULP-A's record lacked documentation of competency evaluation for the following: - hygiene and grooming - standby assistance - medication, exercise and treatment reminders On January 23, 2023, at 11:04 a.m., owner (OW)-C stated registered nurse (RN)-B developed and implemented core training for all ULP. Licensee policy, 5.02 Competency Training Evaluations, dated August 1, 2101, indicated registered nurse (RN) would train and perform competency evaluation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 48 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

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01500	Continued From page 49 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annul training for each 12 months of employment for one of two unlicensed personnel (ULP)-E with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: ULP-E was hired September 24, 2020 prior to the licensee's change of ownership (CHOW). ULP-E's employee training records lacked evidence of up-to-date annual training to include: *Reporting of maltreatment of vulnerable adults under section 626.557 *Review of the assisted living bill of rights *Review of infection control techniques *Effective approaches to use to problem solve when working with a resident's challenging behaviors *Review of the facility's policies and	01500		

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01500	Continued From page 50 procedures *Principles of person-centered planning and service delivery On January 23, 2023, at 11:04 a.m., owner (OW)-C stated registered nurse (RN)-B developed and implemented core training for all ULP. The licensee policy titled, Training Records, dated August 1, 2021, indicated the licensee would maintain a record of staff training and competency. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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	34395	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELEVO HEALTH SERVICES,LLC	4301 WELCOME AVENUE NORTH CRYSTAL, MN 55422

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01620	Continued From page 51 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility licensee failed to provide evidence physical, mental and cognitive needs were assessed with each nursing assessment for two of two residents (R1, R2) reviewed. In addition, the licensee's registered nurse (RN) failed to reassess R1 after he fell three times and was diagnosed with COVID-19. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: Minnesota (MN) Rules 4659.0150, Subpart 1-3, indicated the uniform assessment tool used by licensee to comprehensively evaluate a resident's physical, mental, and cognitive needs. Assessment tool results must be maintained in the resident records. On January 23-25, 2023, the Minnesota Department of Health (MDH) conducted an onsite change of ownership (CHOW) survey. Licensee's assisted living licensure was effective April 11,	01620		

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01620	Continued From page 52 2022. R1 R1 admitted to the facility at unknown date prior to the licensee acquiring the facility on April 11, 2022, in a CHOW. R1's lease agreement was signed on July 15, 2022. R1's service plan dated August 15, 2022, indicated R1 received assistance with personal cares, medication management, behaviors, wandering, falls, post-traumatic stress syndrome (PTSD), shopping, transportation, meals, anxiety, depression, ambulation, and finances. R1 used a seated walker for ambulation outside of the facility. R1's record included a comprehensive nursing assessment dated July 16, 2022. The comprehensive nursing assessment indicated nursing assessed R1's physical, mental, and cognitive needs. At the bottom of the assessment, there was another nursing signature dated August 15, 2022, and listed as a "CHOW" assessment, but no other information added. All subsequent nursing assessments were dated on the same form as the initial comprehensive nursing assessment completed on July 16, 2022. The assessment information, including vital signs, was unchanged from assessment to assessment (July 16, 2022, August 15, 2022, August 29, 2022, and November 15, 2022) and lacked evidence that nursing assessed R1's physical, mental, and cognitive needs with each ongoing assessment. R1's 14-day assessment dated August 29, 2022, indicated R1 had upcoming specialty appointments, and there were no updates to the plan of care. No further information was provided	01620		

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01620	Continued From page 53	01620		

indicating nursing had completed a physical, emotional, or cognitive assessment of R1. Vital signs were unchanged from the initial assessment dated July 16, 2022.

R1's 90 day assessed, dated November 15, 2022, indicated, R1 had a biphasic positive airway pressure (BiPap) machine that staff have been training on but refused using it often. Approved for hearing aids, cream prescribed for skin breakdown on toes, referral for toe nail care due to fungal infection. Updated smoking assessment to independent. No further information was provided indicating nursing had completed a physical, emotional, or cognitive assessment of R1. Vital signs were unchanged the initial assessment dated July 16, 2022.

R1's progress note dated December 10, 2022, at 6:36 a.m., documented by unlicensed personnel (ULP), indicated R1 had three falls during the night shift. The note indicated on December 10, 2022, R1 fell at 1:40 a.m., 3:20 a.m., and approximately 3:40 a.m. R1's record lacked any change of condition assessments, or interventions for falls management.

R1's progress notes dated December 28, 2022, indicated R1 tested positive for covid 19.

R1's record lacked documentation R1 was reassessed by RN-B after he was diagnosed with COVID-19.

R2
R2's medical record was reviewed. R2 was admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a CHOW. R2's diagnoses included type 2 diabetes mellitus, high cholesterol,

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01620	Continued From page 54 obsessive-compulsive disorder, schizoaffective bipolar, and narcissistic personality disorder. R2 walked independently. R2's service plan dated August 12, 202, indicated R2 received assistance with personal cares, medication management, appointments, behaviors, schizoaffective disorder, meals, laundry, housekeeping, and socialization. R2's assessment titled, "Initial Assessment," dated August 12, 2022, indicated the assessment was an intake "CHOW" assessment. R2's 90-day assessment dated November 14, 2022, was entered below the date in a section titled, "90-Day Assessments." The notes section indicated, "R2 is awaiting trial for release from commitment. No changes at this time anticipating changes for move and medication management." The updates section indicated there were no updates. R2's 90-day assessment lacked the required components stated in Minnesota Rules 4659.0150, Subpart 1-3. The assessment failed to identify an assessment of all required components including the resident's personal lifestyle preferences, activities of daily living, instrumental activities, physical health status, emotional and mental health, cognition, communication and sensory capabilities, pain, skin condition, nutrition and hydration, list of treatments, nursing needs, risk indicators, decision making, and need for follow up and referrals. During an exit conference on January 25, 2022, at 1:48 p.m., owner (OW)-C and RN-B indicated the assessment was only required to updated as opposed to completing a comprehensive nursing assessment.	01620		

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01620	Continued From page 55 The licensee policy titled, Assessments, Reviews, and Monitoring, dated August 1, 2021, indicated a licensee RN would conduct nursing assessments on the physical and cognitive needs of the resident. The initial and reassessments must include all the elements of the uniform assessment tool as required, conducted in person (unless unexpected or geographic circumstances), be in writing, dated, and signed by the RN who conducted the assessment. The individualized review or subsequent reviews must include all the required elements as specified in Rule. TIME PERIOD TO CORRECT: Seven (7) days.	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 56 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans for two current residents (R1, R2) with records reviewed had signed addendums. The licensee's facility was acquired in a change of ownership (CHOW). R1 and R2 resided in the facility prior to the licensee acquiring the facility in the CHOW. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On January 23-25, 2023, the Minnesota Department of Health (MDH) conducted an onsite CHOW survey. The licensee's assisted living licensure was effective April 11, 2022. R1 R1 admitted to the facility at unknown date prior to the licensee acquiring the facility in a CHOW. R1's lease agreement was signed on July 15, 2022. R1's service plan dated August 15, 2022, indicated R1 received assistance with personal cares, medication management, behaviors, wandering, falls, post-traumatic stress syndrome	01640		

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01640	Continued From page 57 (PTSD), shopping, transportation, meals, anxiety, depression, ambulation, and finances. R1 used a seated walker for ambulation outside of the facility. R1's record lacked evidence of a signed service plan addendum when the licensee acquired the facility on April 11, 2022. R2 R2's medical record was reviewed. R2 was admitted to the facility at an unknown date prior to April 11, 2022, when the licensee acquired the facility in a CHOW. R2's diagnoses included type 2 diabetes mellitus, high cholesterol, obsessive-compulsive disorder, schizoaffective bipolar, and narcissistic personality disorder. R2 walked independently. R2's lease agreement was signed August 12, 2022. R2's service plan dated August 12, 202, indicated R2 received assistance with personal cares, medication management, appointments, behaviors, schizoaffective disorder, meals, laundry, housekeeping, and socialization. R2's record lacked evidence of a signed service plan addendum when the licensee acquired the facility on April 11, 2022. On January 23, 2023, at 11:04 a.m., registered nurse (RN)-B stated she assessed R1 and R2's needs and documented them in the "6790" rate sheet form utilized by the Minnesota (MN) Department of Human Services (DHS). The licensee policy titled, Service Plan, dated August 1, 2021, indicated service plans would be	01640		

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01640	Continued From page 58 revised based on resident reassessments and monitoring. The service plan would include a signature or other authentication by the licensee and resident, or resident's representative, documenting agreement on services to be provided. The service plan would include a description of the services to be provided based on the most recent assessment and resident preferences. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel (ULP)-A accurately documented when a medication was administered for one resident (R1) with records reviewed. This practice resulted in a level two violation (a	01760		

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01760	Continued From page 59 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1 received services for diagnoses that included hypertension, Wallenberg's stroke syndrome, neuropathy of the lower limbs, sleep apnea, major neurocognitive disorder secondary to a traumatic brain injury, and ataxia. R1's service plan dated August 15, 2022, indicated R1 required medication assistance. On January 24, 2022, at 8:15 a.m., surveyors observed ULP-A administer medications to R1. The medications were observed to be in a prefilled pack from the pharmacy. ULP-A signed the medications as given before the medications were administered to R1. Medications that were observed to be administered: Amlodipine 10 mg tab Bupropion hcl 150 mg xl three tabs Clopidogrel 75 mg tab Famotidine 20 mg tab Losartan pot 50 mg tab Rosuvastatin 5 mg tab On January 24, 2022, at 8:15 a.m., UPL-A acknowledged she documented medications as administered prior to administration of medication.	01760		

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01760	Continued From page 60 Licensee's policy, 7.15 Medication and Treatment Administration and Delegation, dated August 1, 2021, indicated unlicensed personnel would document after medication administration the date, time, dosage, and method of medication administration. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan dated August 15, 2022,	01820		

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01820	Continued From page 61 indicated R1 received services for diagnoses that included hypertension, Wallenberg's stroke syndrome, neuropathy of the lower limbs, sleep apnea, major neurocognitive disorder secondary to a traumatic brain injury, and ataxia. On January 24, 2023, at 8:15 a.m., surveyors observed unlicensed personnel (ULP-A) administer medications to R1. ULP-A said R1's Tolnaftate 1% cream was on hold. The instructions on the electronic medication administration record (EMAR) read as follows, "Tolnaftate 1% cream, apply dime size amount of cream on and around the toes of each foot". The instructions indicated this should be done twice daily at 8:00 a.m. and 8:00 p.m. Surveyors observed ULP-A signed "OH" on the eMAR. ULP-A said "OH" meant "on hold". EMAR documentation for January 2023, indicated the medication was administered consistently at 8:00 p.m. January 2 through January 23, 2023. EMAR documentation for January 2023, indicated the medication was held intermittently at 8:00 a.m. The medication was held at 8:00 a.m. on the following dates: 1/5, 1/6, 1/10, 1/11, 1/12, 1/13, 1/16, 1/17, 1/18, 1/19, 1/20, 1/23, 1/24. EMAR dated January 23, 2023, failed to identify Tolnaftate 1% cream was on hold. R1 record lacked evidence licensee received a prescriber order to hold Tolnaftate 1% cream. Licensee's policy, 7.15 Medication and Treatment Administration and Delegation, dated August 1,	01820		

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01820	Continued From page 62 2021, indicated medications would have current prescriber's orders on file. TIME PERIOD FOR CORRECTION: seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

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01940	Continued From page 63 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one current resident (R1) Treatment and Therapy Management Plan contained specific instructions for R1's nightly use of a bilevel positive airway pressure (BiPAP) machine with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: R1's record was reviewed. R1 admitted to the facility at unknown date prior to the licensee acquiring the facility in a change of ownership (CHOW). R1's service plan dated August 15, 2022, indicated R1 received assistance with personal cares, medication management, behaviors, wandering, falls, post-traumatic stress syndrome (PTSD), shopping, transportation, meals, anxiety, depression, ambulation, and finances. R1 used a seated walker for ambulation outside of the facility. R1's medication/treatment/therapy management plan dated August 15, 2022, indicated R1 required a BiPAP management. The plan indicated registered nurse (RN)-B added BiPAP	01940		

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01940	Continued From page 64 management September 12, 2022. The plan lacked specific instructions for BiPAP including settings, cleanings, and directions for use. The assessment indicated instructions would be on electronic medication administration record (EMAR). R1's EMAR dated January 2023, indicated R1 required a BiPAP "On/Off". The instructions for unlicensed personnel reads as follows, "During the evening ensure R1 has his BiPAP mask on and the purified water canister is full. During the morning make sure the mask and tubing is off and clean." The EMAR start date for BiPAP was September 9, 2022. The instructions lacked identification of settings, and directions for cleaning. R1's progress note embedded in facility Microsoft TEAM progress note, dated January 17, 2022, at 2:27 p.m., written by RN-B, indicated a link to a You Tube video, (https://youtu.be366cRmaRMCw), for unlicensed personnel (ULP) to watch on how to use and care for R1's BiPAP. ULP-A's employee file was reviewed. ULP-A was hired on December 28, 2022. ULP-A's employee record lacked evidence she was competently trained on R1's BiPap. During an interview on January 23, 2021, at 1:45 p.m., R1 said he performed all BiPAP cares. TIME PERIOD FOR CORRECTION: 21 days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34395	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELEVO HEALTH SERVICES,LLC	4301 WELCOME AVENUE NORTH CRYSTAL, MN 55422

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01970	Continued From page 65 There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one current resident (R1)'s record contained an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. R1 required nightly use of a bilevel positive airway pressure (BiPap) machine yet his record lacked evidence of physician orders for his BiPap machine. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan dated August 15, 2022, indicated R1 received services for diagnoses that included hypertension, Wallenberg's stroke syndrome, neuropathy of the lower limbs, sleep apnea, major neurocognitive disorder secondary to a traumatic brain injury, and ataxia.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 66 On January 24, 2023, at 10 a.m., surveyors requested R1's prescriber orders. R1's record included a visit summary from a physician at Minnesota Regional Sleep Disorders Center, dated August 30, 2022. The visit summary indicated R1's machine was not functioning. The visit summary indicated R1 should be using his bilevel 17/11 cm of water. The visit summary notes lacked specific instructions for staff to provide R1's BiPap. R1's electronic medication administration record (EMAR) dated January 2023, indicated R1 required a BiPap "On/Off". The instruction for unlicensed personnel reads as follows, "During the evening ensure R1 has his BiPap mask on and the purified water canister is full. During the morning make sure the mask and tubing is off and clean." The EMAR start date for BiPap was dated September 9, 2022. The instructions lacked identification of settings, and directions for cleaning. R1's record lacked evidence of a medical prescriber order for R1's BiPap machine/treatment that included the name of the resident, a description of the treatment, frequency, duration, and other information needed to administer the treatment. Licensee's policy, &.15 Medications and Treatment Administration and Delegation, dated August 1, 2021, indicated the registered nurse (RN) would document, in writing, specific instructions for each resident and document those instructions in the resident record. TIME PERIOD FOR CORRECTION: seven (7)	01970		

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01970	Continued From page 67 days	01970		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure they had an awake staff person 24 hours per day seven days per week, who was responsible for responding to the requests of residents for assistance with health and safety needs. This affected all two residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: On January 23, 2023, at 9:05 a.m..,the state surveyors entered the facility. At 9:30 a.m., the surveyors observed the January 2023 staff schedule posted on the facility's board. The	02070		

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02070	Continued From page 68 January 2023 staff schedule indicated the same unlicensed personnel (ULP)-E worked every weekend shift that started 7:00 a.m. Saturday morning and ended Sunday 11:00 p.m., for a total of 40 hours for one continuous shift. On January 23, 2023, at 11:55 a.m., owner (OW)-C stated ULP-E worked the 40 hour shift prior to the licensee acquiring the facility from the previous owner. On January 23, 2023, at 11:58 a.m., the Minnesota Department of Health (MDH) verbally informed the licensee of the immediate correction order for failure to have awake staff 24 hours per day, seven days per week. TIME PERIOD FOR CORRECTION: IMMEDIATE On January 23, 2023, at 3:04 p.m., registered nurse (RN)-B handed the surveyors the plan of correction with the updated January 2023 staff schedule. The updated staff schedule indicated ULP-E would work every weekend shift 16 hour shift, from 7:00 a.m. until 11:00 p.m.. From 11:00 p.m. until 7:00 a.m., another ULP was scheduled. ULP-E would return to work a Sunday shift from 7:00 a.m., until 11:00 p.m. On January 23, 2023, at 3:04 p.m., the immediacy of the correction order was lifted; the order remained issued at level F scope/severity for long-term development of the staffing plan to ensure awake staff.	02070		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 69 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure care and services were provided in accordance with accepted healthcare and medical, or nursing standards for one of one resident (R1) with records reviewed. The licensee failed to assess, investigate, or monitor R1 after he fell three times within four hours. The licensee failed to implement individualized interventions to reduce fall risk after R1 fell multiple times. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan dated August 15, 2022, indicated R1 received services for diagnoses that included hypertension, Wallenberg's stroke syndrome, neuropathy of the lower limbs, sleep apnea, major neurocognitive disorder secondary to a traumatic brain injury, and ataxia. R1's progress note dated December 9, 2022, at 5:00 p.m., documented by registered nurse	02310		

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02310	Continued From page 70 (RN)-B, indicated R1 told RN-B he fell off his bed. RN-B's note indicated the fall was unwitnessed and R1's memory, "is declining and fear of falling is increasing". RN-B's notes indicate she would report to PCP (primary care physician) or "psyc" at next appointment. R1's progress note dated December 10, 2022, at 6:36 a.m., documented by unlicensed personnel (ULP), indicated R1 had three falls during the night shift. The note indicated on December 10, 2022, R1 fell at 1:40 a.m., 3:20 a.m., and approximately 3:40 a.m. R1's progress note indicated the following: -1:40 a.m., ULP heard a "loud noise" coming from R1's room and R1 had fallen to the floor. ULP helped him get back into bed. -3:20 a.m., ULP heard "another very loud sound". R1 had fallen to the floor and ULP helped get him into bed. -3:40 a.m., R1 went to the restroom, returned to his room, and slipped off of his bed. R1 required assistance getting his underclothing back on. R1's progress note dated December 10, 2022, at 6:36 a.m., lacked any documentation that nursing was notified of R1's multiple falls. R1's progress notes dated December 16, 2022, at 10:00 a.m., documneted by RN-B indicated R1 told her he had been using over the counter THC (tetrahydrocannabinol) gummies. R1's record failed to identify further assessment or interventions regarding THC gummie use. On January 23, 2023, at 8:00 a.m., an email was sent to owner (OW)-C requesting accident/incident reports for the last 6 months. On January 23, 2023, at 3:50 p.m., an email was	02310		

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02310	Continued From page 71 sent to surveyors with an incident report from R1's fall on December 27, 2022. No other incident reports were provided. R1's record lacked incident reports from December 10, 2022, falls. R1's record lacked ongoing assessment and monitoring of R1 for injury, and lacked documentation a physician was notified. R1's record lacked documentation of an updated nursing assessment, with individualized, interventions to reduce fall risk. During entrance conference on January 23, 2023, 11:05 a.m., surveyors requested RN-B to describe the licensees investigative procedures and implementation of interventions and documentation for falls. RN-B said staff immediately contact RN-B, take vital signs, and assess for injuries. RN-B said she would then follow up with medical provider. Licensess policy titled, Incident Report, dated August 1, 2021, indicated any incident to a resident needed to be reported to licensee management. In addition, all incidents after hours should be reported to the RN on call and the assisted living director as appropriate. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *01/23/23*
Time: 11:00:00
Report: 1013231014

Food and Beverage Establishment Inspection Report

Location:
BELEVO HEALTH SERVICES,LLC
4301 WELCOME AVENUE NORTH
CRYSTAL, MN55422
Hennepin County, 27

Establishment Info:
ID #: N998899
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

FACILITY USES A HOT WATER SANITIZING DISH MACHINE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE.

Comply By: 02/07/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM IS EMPLOYED AT THE FACILITY. COMPLY WITH ABOVE RULE. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 03/27/23

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

RAW CHICKEN WAS THAWING AT ROOM TEMPERATURE ON THE KITCHEN COUNTER. COMPLY WITH ABOVE RULE. DISCUSSED THAWING PROCEDURES WITH STAFF AND REQUESTED MEAT BE PUT IN THE REFRIGERATOR.

Type: Full
Date: *01/23/23*
Time: 11:00:00
Report: 1013231014
BELEVO HEALTH SERVICES,LLC

Food and Beverage Establishment Inspection Report

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Ham
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed on 1/23/23 with the operator and reviewed with MDH Nurse Evaluator M. Larson.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, tile back splash, painted walls, and a textured ceiling. The kitchen finishes and surfaces were well maintained.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is located in the kitchen. The sanitize and high temp cycles are used for washing ware.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, date marking, cleaning, serving highly susceptible populations, and food handling procedures.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231014 of 01/23/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Nicolette Hart
Director

Signed: JM _____

Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us