Electronically Delivered

January 16, 2025

Licensee
Beehive Homes of Lakeville South
8305 210th Street West
Lakeville, MN 55044

RE: Project Number(s) SL40065015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on December 11, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

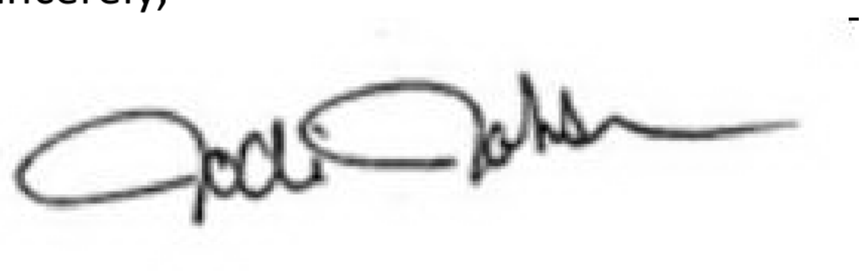
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40065	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LAKEVILLE SOUTH	8305 210TH STREET WEST LAKEVILLE, MN 55044

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40065015-0 On December 9, 2024, through December 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 residents; 18 receiving services under the provisional Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of one unlicensed personnel (ULP-C) during catheter care and toileting. 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:	0 510		

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0 510	Continued From page 4 On December 10, 2024, at 9:48 a.m., the surveyor observed ULP-C assisting R1 on the toilet. ULP-C had donned gloves and explained to R1 that she was going to change his incontinence brief and switch out his full catheter bag to his leg bag. ULP-C removed R1's used incontinence brief and threw it away. ULP-C then removed a piece of split gauze and cleaned around R1's suprapubic catheter (a urinary catheter with tubing placed through the lower abdomen and connected to a drainage bag) site at his lower right abdomen. ULP-C then placed a clean gauze at the insertion site and taped it in place. The surveyor noted the fingertip of ULP-C's right index finger had the glove torn away exposing her fingertip. ULP-C then disconnected R1's full large urine bag from the suprapubic catheter tubing, wiped the tip of the catheter and the leg bag with an alcohol wipe and connected the leg bag tubing to the catheter. ULP-C secured the leg bag to R1's lower right leg, assisted R1 with wiping his bottom, placed a clean incontinence brief, assisted R1 with dressing his lower body with pants and a belt, and assisted him to a standing position with his walker. ULP-C then removed her gloves and donned a clean pair of gloves and finished assisting R1 with dressing his upper body. ULP-C failed to change her gloves and sanitize her hands during the process of changing a dirty brief, providing catheter site care, exchanging catheter bags, and assisting R1 with dressing and transfers. Additionally, ULP-C failed to maintain proper infection control with use of a torn glove/exposed fingertip and direct contact with R1's catheter equipment and failed to sanitize her hands after removal of dirty gloves and before donning clean gloves.	0 510		

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0 510	Continued From page 5 On December 10, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated she expected the ULP to change their gloves and sanitize their hands when working from dirty/contaminated areas to clean areas such as catheter equipment. CNS-C stated R1 had a history of urinary tract infections, and proper technique and glove use was imperative to minimize R1's chances for infection. The licensee's Hand washing policy dated August 1, 2021, indicated proper hand washing techniques should be used to protect the spread of infection hand washing shall be completed after changing diapers or cleaning up after someone who has used the toilet. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 6 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment for a change in condition and wound assessments/measurements for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01620		

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01620	Continued From page 7 REASSESSMENT FOR CHANGE IN CONDITION R1 was admitted to the facility under the assisted living with dementia care license on July 25, 2024. R1's diagnoses included vascular dementia with mood disturbance, anxiety, and heart disease. R1's Service Agreement dated August 9, 2024, included the services of wound care, catheter care, and medication administration. . On December 10, 2024, at 9:48 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R1 with catheter care, dressing, toileting, and wound care. R1's comprehensive assessments since June 2024, were requested. Comprehensive Assessments dated July 16, 2024, July 26, 2024, August 9, 2024, and November 6, 2024, were provided. R1's resident clinical notes indicated: -October 3, 2024, resident had poor urinary output through his suprapubic urinary catheter in the previous 18 hours. R1 was noted to be very fatigued and weak. R1's daughter transported him to the emergency room. (was then admitted to the hospital); -October 5, 2024, resident returned from the hospital via private car around 3:00 p.m. A new order for Sodium Bicarbonate 1300 milligrams (mg) orally twice daily for 15 days was received. Other medication changes were proposed by the hospital physicians. A message was sent to the licensee's provider for clarification of proposed changes.	01620		

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01620	Continued From page 8 R1's record included a hospital discharge summary dated October 5, 2024, and indicated a hospitalization from October 3, 2024, through October 5, 2024, for acute kidney injury on top of chronic kidney disease. The licensee failed to complete a comprehensive assessment with a change in condition related to R1's hospitalization from October 3, 2024, through October 5, 2024. On December 10, 2024, at 11:08 a.m., clinical nurse supervisor (CNS)-C stated she did not complete a comprehensive assessment for a change in condition following R1's hospital discharge on October 5, 2024. WOUND ASSESSMENTS On December 10, 2024, at 10:25 a.m., the surveyor observed ULP-G remove a loose Kerlex wrap (gauze wrap to hold dressings in place) from R1's left elbow. She removed a Telfa pad, cleansed the wound area (approximately three-inch skin tear) with wound wash, covered with non-stick dressings and rewrapped/secured the dressing with Kerlex wrap. ULP-G stated wound care was completed daily and as needed if the dressing was saturated or falling off. R1's Services Delivered (for staff documentation of completed tasks) dated December 2024, indicated daily wound care. R1's Individualized Treatment and Therapy Plan dated December 9, 2024, indicated the treatment of wound care entered to the treatment plan on November 26, 2024. The wound care was scheduled daily and read, "Treat and document wound care: cleanse skin tear to R [right] arm with wound cleanser, cover with non-adherent	01620		

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01620	Continued From page 9 pad, wrap in rolled gauze and secure with tape. Notify registered nurse (RN) of any redness, drainage, warmth, increased pain, swelling, red streaks, fever, etc." R1's progress notes indicated: -November 22, 2024, writer provided wound care to skin tear on L [left] arm. Old dressing stuck to wound; wound cleanser used to remove stuck gauze. Writer applied light layer of Bacitracin, covered with non-adherent pad, wrapped in rolled gauze, and secured. Orders placed for daily wound care until healed. -December 2, 2024, wound care to R [right] arm completed today by writer. Small skin tear bleeding a small amount after removing stuck gauze from wound bed. Cleansed, applied thin layer of Bacitracin, and covered with non-adherent pad and rolled gauze. Wound care service scheduled daily at bedtime for HHA [home health aide] until healed. -December 6, 2024, writer completed wound care on resident's skin tears. Removing old dressing very painful for resident. The licensee's RNs completed dressing changes for R1's left elbow/arm; however, the RNs failed to include an assessment of the wound including measurements, drainage, or condition of the wound (redness, foul odor, healing/non-healing). On December 10, 2024, at 11:08 a.m., CNS-C stated, "I looked at [R1's] wound at least weekly, and was not good about documenting what I've done and that I've assessed the wound." The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes	01620		

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01620	Continued From page 10 in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of seven residents (R3). 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	01760		

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01760	Continued From page 11 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 began receiving services under the licensee's Provisional Assisted Living with Dementia Care license on November 14, 2024. R3's diagnoses included mild cognitive impairment, kidney disease, hypertension, and neuropathy (nerve pain). R3's Service Plan dated November 13, 2024, indicated R3 received medication administration. On December 9, 2024, at 1:40 p.m., the surveyor observed unlicensed personnel (ULP)-E set up medications for R3. ULP-E used a plastic spoon to measure R3's MiraLAX powder (for constipation), instead of inside the container's cap which provided the proper dose marking of 17 grams. The surveyor asked ULP-E "How do you know how much that spoonful is?", ULP-E responded, "I guess I don't know." ULP-E went on to state he usually used the spoon or a plastic graduated medication cup and hadn't thought it would be the wrong dose. He then poured a dose of MiraLAX into the container cap and noted the dose was then much more than what he had been setting up. R3's medication administration record (MAR) dated December 2024, indicated she received two medications for pain, one for depression/anxiety, one for high blood pressure, two for constipation, and two for fluid retention. Furthermore, R3's MAR indicated polyethylene glycol 3350 powder (known as MiraLAX), mix one capful (17 grams) in six to eight ounces of liquid	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40065	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LAKEVILLE SOUTH	8305 210TH STREET WEST LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 12 daily for constipation. R3's signed medication orders dated December 6, 2024, included an order for MiraLAX 17 grams mixed with six to eight ounces of liquid daily. The licensee failed to ensure R3's MiraLAX was accurately measured for the proper dosing as ordered. On December 9, 2024, at 4:30 p.m., clinical nurse supervisor (CNS)-C stated all ULP who pass medications have been trained to use the MiraLAX container cap as the measuring tool to measure the proper dose. She stated she would review this with all staff again. The licensee's Medications and Treatment-Administration and Delegation policy dated August 1, 2021, indicated When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40065	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LAKEVILLE SOUTH	8305 210TH STREET WEST LAKEVILLE, MN 55044

(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
01970	Continued From page 13 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 observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included vascular dementia with mood disturbance, anxiety, and heart disease. R1's Service Agreement dated August 9, 2024, included the services of wound care, catheter care, and medication administration. On December 10, 2024, at 10:25 a.m., the surveyor observed unlicensed personnel (ULP)-G remove a loose Kerlex wrap (gauze wrap to hold dressings in place), from R1's left elbow. She	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40065	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LAKEVILLE SOUTH	8305 210TH STREET WEST LAKEVILLE, MN 55044

(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
01970	Continued From page 14 removed a Telfa pad, cleansed the wound area (approximately three-inch skin tear) with wound wash, covered with non-stick dressings and rewrapped/secured the dressing with Kerlex wrap. ULP-G stated wound care was completed daily and as needed if the dressing was saturated or falling off. R1's Services Delivered (for staff documentation of completed tasks) dated December 2024, indicated daily wound care. R1's progress notes indicated: -November 22, 2024, writer provided wound care to skin tear on L [left] arm. Old dressing stuck to wound; wound cleanser used to remove stuck gauze. Writer applied light layer of Bacitracin, covered with non-adherent pad, wrapped in rolled gauze, and secured. Orders placed for daily wound care until healed. -December 2, 2024, wound care to R [right] arm completed today by writer. Small skin tear bleeding a small amount after removing stuck gauze from wound bed. Cleansed, applied thin layer of Bacitracin, and covered with non-adherent pad and rolled gauze. Wound care service scheduled daily at bedtime for HHA [home health aide] until healed. -December 6, 2024, writer completed wound care on resident's skin tears. Removing old dressing very painful for resident. R1's Individualized Treatment and Therapy Plan dated December 9, 2024, indicated the treatment of wound care entered to the treatment plan on November 26, 2024. The wound care was scheduled daily and read, "Treat and document wound care: cleanse skin tear to R [right] arm with wound cleanser, cover with non-adherent pad, wrap in rolled gauze and secure with tape.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40065	A. BUILDING: _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF LAKEVILLE SOUTH	8305 210TH STREET WEST LAKEVILLE, MN 55044

(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
01970	Continued From page 15 Notify registered nurse (RN) of any redness, drainage, warmth, increased pain, swelling, red streaks, fever, etc." R1's record lacked an order for wound care. On December 10, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-C stated she was unable to locate an order for wound care; furthermore, she stated the licensee did not have standing orders for simple wound care. The licensee's Medication and Treatment Orders-Receiving policy dated August 1, 2021, indicated all orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *12/10/24*
Time: 12:15:00
Report: 1043241362

Food and Beverage Establishment Inspection Report

Location:
BEEHIVE HOMES OF LAKEVILLE SOU
8305 210TH STREET WEST
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0043831
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

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.

NO TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE AN IRREVERSIBLE THERMOMETER OR THERMOLABELS TO MEASURE THE UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F ON A WEEKLY BASIS. COMPLY WITH ABOVE RULE.

Comply By: 12/10/24

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

3-304.14B

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

FACILITY USES QUATERNARY AMMONIA. SANI BUCKET MEASURED 0 PPM. ADVISED STAFF TO MAINTAIN CONCENTRATION BETWEEN 200-400 PPM. STAFF CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 12/10/24

Surface and Equipment Sanitizers

Hot Water: = at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 0 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: KITCHEN SANI DISPENSER
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: MOP SINK SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 1
Violation Issued: No

Process/Item: HEAVY CREAM
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 1
Violation Issued: No

Process/Item: TURKEY
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

Process/Item: BEEF
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2
Violation Issued: No

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

Inspection was completed with Deb Jacobson as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *12/10/24*
Time: 12:15:00
Report: 1043241362
BEEHIVE HOMES OF LAKEVILLE SOU

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 1043241362 of 12/10/24.

Certified Food Protection Manager: Kelci O. Contreras

Certification Number: FM84700 Expires: 06/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Angie Fournelle
Culinary Manager

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us

Report #: 1043241362

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 12/10/24
Time In 12:15:00
Time Out

	Address	City/State	Zip Code	Telephone
BEEHIVE HOMES OF LAKEVILLE SOU	8305 210TH STREET WEST	Lakeville, MN	55044	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0043831		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/10/24

Inspector (Signature)