Electronically Delivered

March 17, 2025

Licensee
Berkeley Heights Home of Minnesota LLC
6917 Edgewood Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37826016

Dear Licensee:

On February 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 23, 2024, survey 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,

Tim Hanna, Supervisor
State Evaluation Team
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

December 4, 2024

Licensee
Berkeley Heights Home Of Minnesota LLC
6917 Edgewood Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37826016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH 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 . . ."

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
In accordance with 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 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

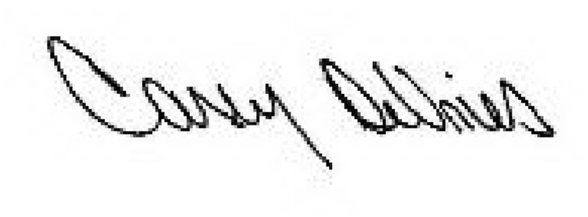
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37826016-0 On October 21, 2024, through October 23, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were four residents residing at the facility, all four received assisted living services.	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 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 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on October 21, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 2 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 infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 22, 2024, at 9:29 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications for R2. R2's medications were stored in a plastic storage bin with a lid. ULP-B performed hand hygiene and applied a new pair of gloves before they began medication	0 510		

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0 510	Continued From page 3 administration. R2 conducted their own blood glucose (BG) checks, using a glucometer, and insulin administration under the supervision and assistance of staff. The surveyor observed R2 check their BG with their glucometer with a result of 155. R2 removed the glucometer test strip with his right index finger and thumb touching the bloodied end of the test strip soiling R2's right hand. With soiled hands, R2 handled the glucometer and its nylon navy blue storage pouch returning the glucometer into the pouch. With soiled hands, R2 handed the soiled glucometer storage pouch to ULP-B. With soiled hands, R2 removed their Novolog and Lantus insulin pens from their storage bin and handed them to ULP-B soiling their gloves. With soiled gloves, ULP-B handled R2's medication administration record (MAR) binder (handwritten on paper). With soiled gloves, ULP-B removed R2's pill box from R2's medication storage bin and put R2's medications into an administration cup and handed them to R2; R2 swallowed the medications. With soiled gloves, ULP-B applied a needle to R2's Novolog and Lantus insulin pens and primed them before handing each pen to R2. With soiled hand, R2 dialed each pen to the number of insulin units to be administered; ULP-B confirmed they were dialed to the correct dose and R2 self-administered the insulin into his abdomen. With soiled gloves, ULP-B returned R2's insulin pens, glucometer pouch and pill box back into R2's medication storage bin. With soiled gloves, ULP-B put the storage bin back into the storage closet touching the doors. The surveyor observed ULP-B remove their gloves for the first time since observations began, ULP-B did not perform hand hygiene. The surveyor observed R2 leave the living room and enter the kitchen, sit down at the dinner table, and eat their breakfast without performing hand hygiene.	0 510		

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0 510	Continued From page 4 On October 22, 2024, at 9:38 a.m., ULP-B stated they should have performed better hygiene when assisting with BG checks and insulin use with R2. ULP-B stated they should have cleaned R2's insulin pens and glucometer equipment and bag before returning it to the medication bin. ULP-B stated they should have had R2 perform hand hygiene as well after touching the test strip. ULP-B stated they were trained by the nurse when they were first hired to removed soiled gloves and to perform hand hygiene before touching clean items. On October 22, 2024, at 9:44 a.m., clinical nurse supervisor (CNS)-A stated ULP-B should have removed their gloves and performed hand hygiene after handling soiled items. CNS-A stated ULP-B was trained by the previous nurse under the previous ownership. CNS-A stated R2 also should have performed hand hygiene appropriately. CNS-A stated there was a bottle of hand sanitizer on a table near the front door which they should have used. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers website, last reviewed on February 27, 2024, indicated, "When to clean your hands - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids or contaminated surfaces	0 510		

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0 510	Continued From page 5 - Immediately after glove removal Gloves are not a substitute for hand hygiene. - If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. - Always clean your hands after removing gloves. - Remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil hands." The licensee's Standard Precautions policy for blood and body fluid precautions, undated, indicated: "2. The principles of Standard Precautions are to be followed by all employees when contacting any such substances or areas. Standard Precautions include the following procedures: -All health care workers will routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. -Gloves will be worn before touching blood and body fluids, mucous membranes or non-intact skin of all patients; for handling items or surfaces soiled with blood or body fluids; and for performing venipuncture and other vascular access procedures. -Gloves will be changed and hands washed after contact with each patient. -Masks and protective eyewear or face shields will be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes. -Gowns or aprons and shoe covers will be worn during procedures that are likely to generate splashes of blood or other body fluids. -CPR resuscitation masks will be used when	0 510		

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0 510	Continued From page 6 rendering resuscitation. For the staff that is CPR certified, the masks are to be carried at all times while rendering care." The licensee's Hand Hygiene/Hand Washing/Hand Cleansing policy, undated, indicated: "1. Indications for Hand Hygiene/ Hand Washing/ Hand Cleansing are: -Before and after direct patient care. -Before and after each procedure. -After using the bathroom. -After blowing or wiping the nose. -Before and after eating and drinking. -Before and after collecting specimen. -When hands are soiled. -After any contact with contaminated materials. -Before entering clinician's bag or patient's clean supplies." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all	0 570		

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0 570	Continued From page 7 residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license effective May 15, 2024, through May 14, 2025. On October 21, 2024, at 10:52 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed the licensee had two enlarged copies of their assisted living license; one was posted in the upstairs living room and the second was posted in the basement living room. The surveyor observed neither posted assisted living license was an original copy. On October 21, 2024, at 11:10 a.m., licensed assisted living director (LALD)-D stated they did not have their original license posted due to resident behavior which sometimes included tearing down postings on the wall. On October 22, 2024, at 12:51 p.m., administrator (A)-C and CNS-A stated they would get the original license posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		

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0 780	Continued From page 8	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and 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	0 780		

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0 780	Continued From page 9 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: On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 10:40 a.m. and 1:00 p.m. the following deficient conditions were observed: LINT: The surveyor observed an excessive amount of lint behind the clothes dryer in the lower level of the facility. The surveyor explained to the CNS-A that the lint collection poses a fire hazard and the area behind the dryer shall routinely be cleaned. EMERGENCY ESCAPE AND RESCUE OPENINGS: The surveyor observed that the emergency escape windows in resident rooms 4 and 5 were blocked from fully opening by a cover, rocks/vegetation and that the window well size does not the state fire code requirements and prohibits the emergency escape window from fully opening. The surveyor explained to the CNS-A that the emergency escape windows shall be always fully openable without any special knowledge and that they shall not be blocked. Also, the window well size shall meet the state fire code requirements.	0 780		

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0 780	Continued From page 10 The minimum horizontal area of the window well shall be 9 square feet, with a minimum dimension of 36 inches. The area of the window well shall allow the emergency escape and rescue opening to be fully opened. The deficient conditions were visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790		

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0 790	Continued From page 11 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 facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 10:40 a.m. and 1:00 p.m. the following deficient condition was observed: The portable fire extinguishers throughout the facility needed their annual inspection. The surveyor explained to the CNS-A that all fire extinguishers shall have the annual inspection completed to meet the state fire code requirements. The deficient condition was visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 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, 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: On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 10:40 a.m. and 1:00 p.m. the following deficient conditions were observed: BATHROOM: The surveyor observed tile missing, water dripping from the shower head creating water-soaked flooring and wall, drain missing the cover and mold in and near the shower in the lower level bathroom. There was also a hole in the wall in the same bathroom. YARD:	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 13 The surveyor observed excessive brush/leaves/needles/dried vegetation throughout the property. Cigarette butts were observed being discarded onto the ground where all the brush/leaves/needles/dried vegetation were located. The deficient conditions were visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 14 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on October 22, 2024, at approximately 12:30 p.m. with the clinical nurse supervisor (CNS)-A on the fire safety and evacuation plan for the facility, training on the fire safety and evacuation plan and fire drills. FIRE SAFETY EVACUATION PLAN:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

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BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 15 During record review the surveyor noted that the resident room numbers were not on the fire safety and evacuation floor plan and that the floor plan was not in the fire safety and evacuation binder. The surveyor explained to the CNS-A that the resident room numbers shall be put on the fire safety and evacuation plan and that a copy of both levels shall be put in the fire safety and evacuation binder. TRAINING: The CNS-A stated they would email the training records on the fire safety and evacuation plan for their employees and residents to this surveyor. DRILLS: The CNS-A stated they would email the fire drill records to this surveyor. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

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BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

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0 820	Continued From page 16 a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: IMMEDIATE ORDER: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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: On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 10:40 a.m. and 1:00 p.m. the following deficient condition was observed: OCCUPIED RESIDENT ROOM: Resident sleeping room 2 emergency escape and rescue clear window opening measurements is 32" X 16" X 36". This resident room is on the upper level of the facility. The window does not meet the 20 inches minimum requirements for height. The window was measured by the surveyor with the CNS-A present.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37826	A. BUILDING: _____ B. WING _____	10/23/2024

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BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

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0 820	Continued From page 17 Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. Surveyor explained to CNS-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. CNS-A stated they would complete a fire watch until a code compliant escape window is installed. The deficient condition was visually verified by CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Immediate. NON-IMMEDIATE ORDER: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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:	0 820		

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0 820	Continued From page 18 On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 10:40 a.m. and 1:00 p.m. the following deficient conditions were observed: SMOKING: The surveyor observed a large amount of cigarette butts discarded on the ground next to and under the wood deck near dry vegetation in the back of the facility. The surveyor also observed a hole burned in the wood deck as well as burn marks in the wood floor and on the vinyl windowsill in resident room 3. There was also evidence of cigarette ash on the windowsill. Surveyor explained to CNS-A that an approved receptacle shall be provided for cigarette butts and that all employees and residents shall always use the receptacle and there shall be no discarding of cigarette butts on the ground/deck or on the floor inside the facility. The deficient conditions were visually verified by CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

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	37826	A. BUILDING: _____ B. WING _____	10/23/2024

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01880	Continued From page 19 Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for two of two residents (R2, R3) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, at 10:52 a.m., during the facility tour the surveyor observed the medication refrigerator on the first floor living room with clinical nurse supervisor (CNS)-A. The surveyor observed a sign on the refrigerator door which indicated, "The normal temperature should be between 35-40 degrees Fahrenheit." The refrigerator's round stainless-steel thermometer read 38 degrees F. The surveyor observed a thick layer of frost and ice built up on the top shelf of the medication refrigerator. CNS-A stated they tracked the refrigerator's temperature in Rtask (charting software) and would provide the temperature log. The surveyor observed the following medications in the refrigerator: -R2's Lantus Solostar 100u/ml, one box; -R2's insulin lispro Kwikpen 100U/ml, one box; -R3's Lantus Solostar 100u/ml injection, one box; and -R3's Novolog Flexpen 100u/ml injection pens, one box.	01880		

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BERKELEY HEIGHTS HOME OF MINNESOTA L	6917 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

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01880	Continued From page 20 R2 R2 was admitted to the licensee on February 17, 2023, and had a diagnosis of type two diabetes. R2's Service Plan dated June 9, 2024, indicated R2 received medication management. R2's Medication Administration Record (MAR) for October 2024, indicated R2 took the following medications: -Lantus Solostar 100 units (u)/milliliter (ml) injection, inject 25 units (u) subcutaneously (SQ) once daily; and -Lispro Kwikpen 100U/ml, inject 5u SQ up to three times per day before eating a meal, drinking regular or eating dessert, max dose of 15u in 24 hours. R3 R3 was admitted to the licensee on January 25, 2024, and had a diagnosis of type one diabetes. R3's Service Plan dated June 10, 2024, indicated R3 received medication management. R3's MAR for October 2024, indicated R3 took the following medications: -Lantus Solostar 100u/ml injection, inject 12u SQ every morning; -Novolog Flexpen 100u/ml injection; inject 1u SQ per 15 grams (g) of carbs for meals and snacks. The licensee's Refridgerator and Freezer Temperature Log - October 2024, indicated the, "Living room MINI Refridgerator temperature," had the following temperatures which included five days with temperatures below freezing (32 degrees F): -October 1; 34 degrees Fahrenheit (F);	01880		

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	37826	A. BUILDING: _____ B. WING _____	10/23/2024

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01880	Continued From page 21 -October 2 and 3; 35 degrees F; -October 4; 32 degrees F; -October 5 and 6; 30 degrees F; -October 7-9; 29 degrees F; -October 10-12; 35 degrees F; -October 13; no temperature logged; -October 14; 35 degrees F; -October 15 and 16; 33 degrees F; -October 17; 35 degrees F; -October 18 and 19; 33 degrees F; and -October 20; 34 degrees F. On October 21, 2024, at 11:10 a.m., licensed assisted living director (LALD)-D (who was also a registered nurse (RN)) and CNS-A stated they understood the concerns with the temperatures on the medication refrigerator log because they were aware of insulin storage temperature requirements. CNS-A stated they would thaw the ice from the refrigerator and update the temperature sign on the door. Both stated they did not document if action was taken for temperatures outside of parameters. On October 22, 2024, at 9:29 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with Lantus and Lispro insulin administration. Manufacturer instructions for Lantus, last revised in 2022, indicated store unused Lantus in a refrigerator between 36-46 degrees F; discard if Lantus has been frozen. Manufacturer instructions for Humalog (insulin lispro), last revised on July 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not use if it has been frozen. Manufacturer instructions for Novolog (insulin aspart), last revised in February 2023, indicated	01880		

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01880	Continued From page 22 to store unused pens in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "9. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *10/21/24*
Time: 11:30:00
Report: 1051241153

Food and Beverage Establishment Inspection Report

Location:
Berkeley Heights Home Llc
6917 Edgewood Avenue North
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0039232
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124339949
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

THE MILK IN THE MAIN KITCHEN UPRIGHT COOLER READ 45 DEG F. TURN UNIT COOLER OR MOVE TCS FOOD TO ANOTHER COLD HOLDING UNIT.

Comply By: 10/21/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: MILK
Violation Issued: Yes

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

MET WITH NURSE EVALUATOR, JOEY KEEN:

DISCUSSED THE FOLLOWING WITH MARION,

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE

THE KITCHEN HAS A COMMERCIAL HIGH TEMPERATURE DISHWASHER, SMOOTH TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, AND TILE FLOORING.

Type: Full
Date: *10/21/24*
Time: 11:30:00
Report: 1051241153
Berkeley Heights Home Llc

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 1051241153 of 10/21/24.

Certified Food Protection Manager: Sheikh K. Dukuly II

Certification Number: FM109724 Expires: 02/11/28

Inspection report reviewed with person in charge and emailed.

Signed:_____
Marion Gbatu

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us