



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 7, 2026

Licensee

Belevo Health Services, LLC
1064 Dale Street North
Saint Paul, MN 55117

RE: Project Number(s) SL37996016

Dear Licensee:

On November 4, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 13, 2025. 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,

A handwritten signature in black ink that reads 'Stephanie Jones de Palma'.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 28, 2025

Licensee

1-Belevo Health Services LLC

1064 Dale Street North

Saint Paul, MN 55117

RE: Project Number(s) SL37996016

Dear Licensee:

On August 6, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 13, 2025 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last , completed on February 13, 2025, found not corrected at the time of the August 6, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on August 6, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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 may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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>

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.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is written in a cursive, flowing style with a horizontal line extending from the end.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37996	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/06/2025
NAME OF PROVIDER OR SUPPLIER BELEVO HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1064 DALE STREET NORTH SAINT PAUL, MN 55117		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37996016-2 On 8/6/2025 , the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on 5/14/2025. At the time of the survey, there were 6 residents; 6 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 680}	Continued From page 1 (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. This MN Requirement is not met as evidenced by:	{0 680}			
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this survey		

Minnesota Department of Health

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{0 775}	Continued From page 2 Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 6, 2025 at approximately 1:30 pm., the surveyor toured the facility with facility staff. During the tour, the surveyor asked staff to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 3: One window measuring 27.5 inches clear width, 16 inches clear height, and 440 square inches total openable area. The height from the floor to the windowsill measuring 49 inches. UNOCCUPIED SLEEPING ROOMS:	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 3 Resident sleeping room 1: One window measuring 27.5 inches clear width, 17 inches clear height, and 467.5 square inches total openable area. The height from the floor to the windowsill measuring 49 inches. The windows in resident sleeping rooms 1, and 3 did not meet the minimum requirements for opening height. The windows in resident sleeping rooms 1, and 3 did not meet the minimum requirements for total openable area. The windows in resident sleeping rooms 1, and 3 did not meet maximum requirements for windowsill height Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Egress windows in existing sleeping rooms must have sill height of not more than 44 inches above the floor without permanently affixed ladders or stairs. Surveyor explained to sraff that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Staff obtained a copy of the surveyors business card and indicated it would be passed along to program director (PD)-A who reportedly would send documentation to the surveyor regarding the windows. To date no further information has	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 4 been received by the surveyor.	{0 775}			
{0 780} SS=I	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:	{0 780}			
			Not reviewed during this survey		

Minnesota Department of Health

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{0 800}	Continued From page 5	{0 800}	Not reviewed during this survey		
{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:	{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) staff 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) Staff 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	{0 810}			

Minnesota Department of Health
STATE FORM 6899 9BC413 If continuation sheet 7 of 9

Minnesota Department of Health

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{01500}	Continued From page 7 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, 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.	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 8 This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 8, 2025

Licensee
1-Belevo Health Services LLC
1064 Dale Street North
Saint Paul, MN 55117

RE: Project Number(s) SL37996016

Dear Licensee:

On May 14, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 13, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 13, 2025, found not corrected at the time of the May 14, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a) - \$3,000.00

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on May 14, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you 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:

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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.

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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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna', is written over a light gray rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37996016-1 On May 14, 2025 the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on february 13, 2025. At the time of the survey, there were 6 residents; 6 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/or issued.	{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.		
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Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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{0 680}	Continued From page 1 (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. This MN Requirement is not met as evidenced by:	{0 680}			
{0 775} SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}	Not reviewed during this survey		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37996	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/14/2025
NAME OF PROVIDER OR SUPPLIER BELEVO HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1064 DALE STREET NORTH SAINT PAUL, MN 55117		
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{0 775}	Continued From page 2 Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 14, 2025 at approximately 12:28pm., the surveyor toured the facility with program director (PD)-A. During the tour, the surveyor asked PD-A to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 3: One window measuring 28 inches clear width, 16 inches clear height, and 448 square inches total openable area. The height from the floor to the windowsill measuring 49 inches.	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 3 Resident sleeping room 5: One window measuring 30 inches clear width, 20 inches clear height, and 600 square inches total openable area. Resident sleeping room 7: One window measuring 30 inches clear width, 21 inches clear height, and 630 square inches total openable area. UNOCCUPIED SLEEPING ROOMS: Resident sleeping room 1: One window measuring 28 inches clear width, 16 inches clear height, and 448 square inches total openable area. The height from the floor to the windowsill measuring 49 inches. Resident sleeping room 6: One window measuring 30 inches clear width, 20.5 inches clear height, and 615 square inches total openable area. The windows in resident sleeping rooms 1, and 3 did not meet the minimum requirements for opening width. The windows in resident sleeping rooms 1, 3, 5, 6, and 7 did not meet the minimum requirements for total openable area. The windows in resident sleeping rooms 1, and 3 did not meet maximum requirements for windowsill height Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 4 Egress windows in existing sleeping rooms must have sill height of not more than 44 inches above the floor without permanently affixed ladders or stairs. Surveyor explained to PD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. PD-A stated that they were under the impression that the windows would be replaced and were supplied a copy of the surveyors business card and requested to email permits and invoices for windows. To date no further information has been received by the surveyor.	{0 775}			
{0 780} SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 5 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide and maintain functional smoke alarms where required in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This deficient condition had the ability to affect all staff and 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). The findings include: On May 14, 2025, at approximately 12:28 pm., the surveyor toured the facility with program director (PD)-A. During the tour, the surveyor asked PD-A to test the smoke alarms resident room 5. Upon testing, it was found that the smoke alarms in resident room 5 were not sounding when tested. PD-A tested the smoke alarms provided in the kitchen and bedroom and neither alarm sounded. PD-A indicated that smoke alarms may not be present and functional and would not like	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 6 to further test and disturb resident. Smoke alarms are required in each room used for sleeping purposes. Smoke alarms are required outside each separate sleeping area in the immediate vicinity of bedrooms. Smoke alarms are required on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics. Smoke alarms are required to be functional when tested. On May 14, 2025, the surveyor explained to PD-A that smoke alarms must be maintained in a functional state.. PD-A stated they understood the requirements for smoke alarms and would immediately start the process of restoring alarms to functional working order or otherwise providing smoke alarm coverage for resident room 5.	{0 780}			
{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:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}	Not reviewed during this survey		

Minnesota Department of Health

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{0 810}	Continued From page 7 (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) staff 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) Staff 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 staff 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:	{0 810}	Not reviewed during this survey		

Minnesota Department of Health

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{01500}	Continued From page 8	{01500}			
{01500} SS=F	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; (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.	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 9 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, 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:	{01500}	Not reviewed during this survey		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 17, 2025

Licensee

1-Belevo Health Services LLC

1064 Dale Street North

Saint Paul, MN 55117

RE: Project Number(s) SL37996016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 2025, 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 . . ."

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 may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 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.

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

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.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

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,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37996	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2025
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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: SL#37996016-0 On February 10, 2025, through February 13, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom were receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
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	0 680			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 680	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on 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 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).	0 680			

Minnesota Department of Health

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0 680	Continued From page 2 The findings include: The licensee's undated emergency preparedness plan lacked the following required content: -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On February 11, 2025, at 11:30 a.m., owner (O)-D stated that the licensee did not have documentation of two emergency preparedness exercises and she had not understood the requirement. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated the licensee's emergency preparedness plan will include all required elements of Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775			

Minnesota Department of Health

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(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	
0 775	Continued From page 3 Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect some residents, staff, and visitors. 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). The findings include: On February 10, 2025, from approximately 1:02 p.m. to 2:35 p.m., the surveyor toured the facility with site supervisor, unlicensed personnel (ULP)-B. During the tour, the surveyor asked ULP-B to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 3: One window measuring 28 inches clear width, 16 inches clear height, and 448 square inches total openable area. The height from the floor to the windowsill measuring 49 inches.	0 775			

Minnesota Department of Health

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0 775	Continued From page 4 Resident sleeping room 5: One window measuring 30 inches clear width, 20 inches clear height, and 600 square inches total openable area. Resident sleeping room 7: One window measuring 30 inches clear width, 20 inches clear height, and 600 square inches total openable area. UNOCCUPIED SLEEPING ROOMS: Resident sleeping room 1: One window measuring 28 inches clear width, 16 inches clear height, and 448 square inches total openable area. The height from the floor to the windowsill measuring 49 inches. Resident sleeping room 6: One window measuring 30 inches clear width, 20 inches clear height, and 600 square inches total openable area. The windows in resident sleeping rooms 1, and 3 did not meet the minimum requirements for opening width. The windows in resident sleeping rooms 1, 3, 5, 6, and 7 did not meet the minimum requirements for total openable area. The windows in resident sleeping rooms 1, and 3 did not meet maximum requirements for windowsill height Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 775			

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0 775	Continued From page 5 Egress windows in existing sleeping rooms must have sill height of not more than 48 inches above the floor without permanently affixed ladders or stairs. Surveyor explained to ULP-B and program director (PD)-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. PD-A stated that they had been unaware of the size requirements but confirmed understanding of the requirements stated by the surveyor during the survey and requirement to obtain any applicable permits for alterations. On February 10, 2025, the surveyor explained to PD-A that an immediate correction order was issued for the above findings. PD-A stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. There was not a clear path from the rear egress door to the right of way due to accumulation of snow which had not been shoveled. Resident room 5 contained a space heater in the bedroom which was surrounded by clothing and materials on the floor around the device, as well as plastic items placed on top of the heater. The space heater did not have adequate clearance from objects based upon manufacturer specifications. Clearance should be provided around heating elements to avoid potential combustion hazard. A significant number of boxes, plastic shelves and other items were stored directly next to the	0 775			

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0 775	Continued From page 6 furnace in the maintenance room. The stored items were noticeably warm to the touch when investigated by the surveyor. Clearance should be maintained around heating equipment to avoid combustion of nearby items. TIME PERIOD FOR CORRECTION: Immediate	0 775			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780			

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0 780	Continued From page 7 failed to provide and maintain functional smoke alarms. This deficient condition had the ability to affect all staff and 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). The findings include: On February 10, 2025, from approximately 1:02 p.m. to 2:35 p.m., the surveyor toured the facility with site supervisor, unlicensed personnel (ULP)-B. During the tour, the surveyor asked ULP-B to test the smoke alarms resident sleeping rooms. Upon testing, it was found that the smoke alarms in resident room 5 were not sounding when tested. ULP-B tested the smoke alarms provided in the kitchen and bedroom and neither alarm sounded. ULP-B stated that the alarms had been functional during testing recently and was unsure why the alarms were not sounding upon testing. An examination of the alarms revealed that the alarms did not have batteries installed during the time of testing. ULP-B was unable to locate replacement batteries for the alarms. The surveyor advised that the smoke alarms must be maintained in functional order for resident and facility safety. Smoke alarms are required in each room used	0 780			

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0 780	Continued From page 8 for sleeping purposes. Smoke alarms are required outside each separate sleeping area in the immediate vicinity of bedrooms. Smoke alarms are required on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics. Smoke alarms are required to be functional when tested. On February 10, 2025, the surveyor explained to program director (PD)-A that an immediate correction order was issued for the above findings. PD-A stated they understood the requirements for smoke alarms and would immediately start the process of restoring alarms to functional working order or otherwise providing smoke alarm coverage for resident room 5. TIME PERIOD FOR CORRECTION: Immediate	0 780			
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	0 800			

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0 800	Continued From page 9 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 of the residents). The findings include: On February 10, 2025, from approximately 1:02 p.m. to 2:35 p.m., the surveyor toured the facility with site supervisor, unlicensed personnel (ULP)-B and observed the following deficient conditions: Resident room 2 had damage to the wall behind the kitchen sink including an open hole in wall and base of cabinet. Resident room 2 bathroom ventilation fan was visibly covered with dust and made a loud grinding noise when switched on. Resident room 2 bathroom toilet paper holder is damaged and not securely attached to the wall. The holder is hanging loose from the wall exposing its edges. Resident room 5 had damage to the wall behind the kitchen sink including an open hole in wall and base of cabinet. Resident room 5 was not maintained in proper state of cleanliness with refuse, clothing, food, crumbs and a hypodermic style needle strewn	0 800			

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0 800	Continued From page 10 about the furniture and floor. Resident rooms must be maintained in safe and sanitary manner. ULP-B stated that the rooms are cleaned on a regular basis and was unsure how the room was in such a state but acknowledged the unclean condition. Resident room 5 bedroom contained an electrical outlet which was not supplied with protective outlet cover. Resident room 5 bathroom ventilation fan was not functional when tested by surveyor. ULP-B acknowledged that the bathroom fan did not activate when switched on. Resident room 5 bathroom flooring was coming loose around the toilet. The damaged floor was not maintained in proper condition and impervious to water. Flooring should be maintained in clean, sanitary and undamaged condition. Resident room 6 had damage to the wall behind the kitchen sink including an open hole in wall and base of cabinet. Resident room 6 had a ground fault interrupter (GFI) outlet in the bathroom which was not functional when tested. The outlet indicated that it had been tripped, and was unable to be reset when attempted by ULP-B and surveyor. During the facility tour on February 10, 2025, these deficient conditions were visually verified by ULP-B accompanying on the tour and both stated they understood requirements to comply with property maintenance conditions. The front step to the facility was cracked and damaged with sections that have fallen loose.	0 800			

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0 800	Continued From page 11 Steps should be maintained in proper condition free of cracks or holes that may contribute to tripping hazard. TIME PERIOD FOR CORRECTION: Seven (7) 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) staff 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) Staff 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 staff 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	0 810			

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0 810	Continued From page 12 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 and provide the required resident training. 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: On February 10, 2025, at approximately 2:30 p.m., program director (PD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety, and evacuation training. The licensee's FSEP failed to include the following: The FSEP was located in the staff unit, a space which according to PD-A, is locked on occasion. The FSEP must be stored in a location where it is readily available at all times in the facility. PD-A stated that the facility had plans to move the FSEP to an area near the front door The FSEP did not identify specific fire protection	0 810			

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0 810	Continued From page 13 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP did not include any documentation of training provided to residents on fire safety or evacuation procedures. Trainings must be offered to residents capable of assisting in their own evacuation at least once annually. During interview on February 10, 2025, the surveyor explained the requirements for frequency of drills, resident training, employee training, and documentation. PD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01500 SS=F	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; (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	01500			

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01500	Continued From page 14 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, 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.	01500			

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01500	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure eight hours of annual training was provided for each 12 months of employment, and included all required topics, for one of two employees (clinical nurse supervisor (CNS)-C). 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: CNS-C was hired on January 11, 2022, to provide supervision of staff and direct care services to residents. CNS-C's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -reporting maltreatment of vulnerable adults or minors; -assisted Living Bill of rights; -infection control techniques; -review of provider's policies and procedures; and -principles of person-centered planning/service delivery. On February 11, 2025, at 12:00 p.m., owner (O)-D stated that she did not think that nurses needed to complete the annual training	01500			

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01500	Continued From page 16 requirement. The licensee's 5.06 Annual Required Staff Training policy, dated April 5, 2024, indicated staff that perform direct care services would complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

Type: Full
Date: 02/11/25
Time: 22:39:34
Report: 1021251029

Food and Beverage Establishment Inspection Report

Page 1

Location:

Belevo Health Services, Llc
1064 Dale Street North
St Paul, MN55117
Ramsey County, 62

Establishment Info:

ID #: N012345
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529947818
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.

No NEW orders were issued during this inspection.

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

ON-SITE VISIT WITH OWNER, BRITTANY MCMILLIAN, AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ROBYN WOOLLEY.

THIS FACILITY HAS INDEPENDENT LIVING APARTMENTS. EACH APARTMENT HAS THEIR OWN PRIVATE KITCHEN.

THERE IS NO MAIN KITCHEN OR SHARED DINING AREA.

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 1021251029 of 02/11/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

BRITTANY MCMILLIAN
OWNER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us