DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 15, 2023

Licensee
Beehive Homes Of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN 55311

RE: Project Number(s) SL35125015

Dear Licensee:

On May 23, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 8, 2023, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

March 31, 2023

Licensee
Beehive Homes Of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN 55311

RE: Project Number(s) SL35125015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 8, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

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

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(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: SL35125015-0 On March 6, 2023, through March 8, 2023, 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 33 active residents receiving services under the Assisted Living with Dementia Care license. Two immediate correction orders were identified on March 7, 2023, issued for SL35125015-0, tag identifications 1290 and 1750. On March 8, 2023, the immediacy of correction orders 1290 and 1750 was removed, however non-compliance remained at a scope and level of I and G, respectively.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 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 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 dated March 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	0 550		

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0 550	Continued From page 2 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors and all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 10:30 a.m., during the facility tour, the surveyor observed the licensee	0 550		

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0 550	Continued From page 3 lacked posting of the above required content in a conspicuous place. On March 6, 2023, at 4:05 p.m., director of services (DS)-C provided the surveyor with a grievance form, the form lacked information to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On March 8, 2023, at 12:05 p.m., licensed assisted living director (LALD)-B confirmed the required content had not been posted, and stated the licensee will update their forms to reflect the statute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	0 630		

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0 630	Continued From page 4 Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include an individualized review or assessment of the person's susceptibility to be abused by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 R3 was admitted to the licensee November 2, 2022, with the following diagnoses: Parkinson's disease and neurocognitive disorder with Lewy bodies dementia. R3's Individual Abuse Prevention Plan dated December 13, 2022, indicated R3 had the following needs; activities of daily living (ADL), activity capabilities. medication administration, social and cognitive. R3's IAPP lacked any specific documentation of: - the person's susceptibility to be abused by another individual, or other vulnerable adults; - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be	0 630		

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0 630	Continued From page 5 taken to minimize the risk of abuse to that person and other vulnerable adults. On March 8, 2023, at 9:00 a.m., registered nurse (RN)-F acknowledged that R3's IAPP lacked required documentation on assessment of the vulnerable adult. RN-F further stated that the previous director of nursing must have missed having this completed. The licensee's Vulnerable Adult Maltreatment -Prevention and Reporting policy dated August 1, 2021, indicated "Consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [Licensee] prohibits the maltreatment of residents. To support this prohibition, [Licensee] educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). [Licensee] also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information." No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 6 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D started employment with licensee June 21, 2021, under the comprehensive licensee and started providing assisted living services August	0 650		

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0 650	Continued From page 7 1, 2021. On March 6, 2023, at 12:28p.m., the surveyor observed ULP-D training ULP-K to pass medications to residents of the memory care unit. On March 7, 2023, at approximately 7:30 a.m., the surveyor and ULP-D observed the contents of the medication cart in the memory care unit where ULP-D was scheduled to pass medications. On March 7, 2023, at 9:25 a.m., ULP-D stated she completed new hire orientation but could not remember if the specific training was completed as there are many other trainings completed with licensee. ULP-D's employee record lacked evidence ULP-D received orientation to assisted living facility licensing requirements and regulations to include the following topics: - Overview of Assisted Living statutes; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery. In addition ULP-D's employee record lacked evidence of completed training and competency evaluation to include the following topics: - documentation requirements for all services provided; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	0 650		

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0 650	Continued From page 8 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; - medication, exercise, and treatment reminders; - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the client; and - administering medications or treatments as required. On March 7, 2023, at 1:40 p.m., registered nurse (RN)-A acknowledged ULP-D's employee record was missing the required training and competency evaluations. In addition, RN-A stated the licensee was not aware ULP-D's training record was missing content and stated all training was provided at hire and will ensure the training is completed. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated a registered nurse or licensed health professional staff of licensee delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a health history and symptom screening for two of three employees (unlicensed personnel (ULP)-D, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 660		

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0 660	Continued From page 10 has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 9:55 p.m., during the entrance conference registered nurse (RN)-A stated the licensee completed a two-step tuberculin skin test (TST) for all the employees. The licensee's Facility Tuberculosis (TB) Risk Assessment Worksheet completed November 20, 2019, indicated licensee had a low risk level for TB. ULP-D ULP-D started employment with licensee June 21, 2021, under the comprehensive licensee and started providing assisted living services August 1, 2021. ULP-D's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) indicating ULP-D had a TST - first step administered January 25, 2022, and read January 29, 2022. ULP-J ULP-J started employment with licensee September 24, 2019, under the comprehensive licensee and started providing assisted living services August 1, 2021. ULP-J's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) indicating ULP-J had a TST - first step administered February 15, 2022, with no results recorded. ULP-D and ULP-J's employee records lacked the	0 660		

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BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(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
0 660	Continued From page 11 required second step TST. On March 8, 2023, at 12:15 p.m., RN-F and licensed assisted living director (LALD)-B confirmed ULP-D and ULP-J's records lacked a second step TB test. In addition, LALD-B stated it was difficult for the licensee to keep up TST as it was time consuming and unreliable to track and maintain records. LALD-B also stated licensee will soon start using gold TB test (a blood test). The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 12 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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).	0 810		

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0 810	Continued From page 13 A record review of available documentation and interview were conducted on March 8, 2023, at approximately 10:00 a.m. of documents provided by director of services (DS)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated there was not an evacuation floor plan posted in the facility or located in the fire safety and evacuation plan indicating location and number of resident rooms, primary evacuation routes and exits. Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did	0 810		

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0 810	Continued From page 14 not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by DS-C during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for six of six employees (unlicensed personnel (ULP)-D, ULP-E, ULP-G, ULP-H, ULP-I, ULP-J). This practice resulted in a level three violation (a	01290		

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01290	Continued From page 15 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: ULP-D ULP-D started work at the licensee's facility on June 21, 2021, under the comprehensive license and started providing assisted living services August 1, 2021. On March 6, 2023, at 12:28p.m., the surveyor observed ULP-D training ULP-K to pass medications to residents of the memory care unit. On March 7, 2023, at approximately 7:30 a.m., the surveyor and ULP-D observed the contents of the medication cart in the memory care unit where ULP-D was scheduled to pass medications. ULP-D's background study clearance record dated June 24, 2021, was completed under the licensee's closed comprehensive home care license health facility identification number (HFID) 34912, not the licensee's current HFID 35125. On March 7, 2023, at approximately 11:10 a.m., the Department of Human Services (DHS) NetStudy 2.0 website indicated ULP-D was not listed on the licensee's roster of cleared background studies. ULP-E	01290		

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01290	Continued From page 16 ULP-E started work at the licensee's facility on January 17, 2023. On March 6, 2023, at approximately 1:10 p.m., the surveyor observed ULP-E assist R2 and R3 with medication administration. ULP E's employee record included a NetStudy application dated January 23, 2023, at 9:18:24 a.m., but lacked evidence of a completed background study clearance. On March 7, 2023, at 11:08 a.m., the NetStudy website indicated ULP-E was separated on February 7, 2023, and should be removed from direct patient care. On March 7, 2023, at 11:28 a.m., the NetStudy website indicated ULP-E's background was updated as cleared. ULP-G ULP-G started work at the licensee's facility on February 8, 2021, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-G's background study clearance record dated February 9, 2021, was completed under the licensee's closed comprehensive home care license HFID 34912, not the licensee's current HFID 35125. ULP-H ULP-H started work at the licensee's facility on June 8, 2021, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-H's background study clearance record	01290		

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01290	Continued From page 17 dated June 8, 2021, was completed under the licensee's closed comprehensive home care license HFID 34912, not the licensee's current HFID 35125. ULP-I ULP-I started work at the licensee's facility on November 11, 2019, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-I's background study clearance record dated November 9, 2019, was completed under the licensee's closed comprehensive home care license HFID 34912, not the licensee's current HFID 35125. ULP-J ULP-J started work at the licensee's facility on October 10, 2019, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-J's background study clearance record dated September 24, 2019, was completed under the licensee's closed comprehensive home care license HFID 34912, not the licensee's current HFID 35125. On March 7, 2023, at 11:20 a.m., licensed assisted living director (LALD)-B acknowledged ULP-E's, NetStudy background check was cleared as of March 7, 2023, after the initiation of the survey. In addition, ULP-D, ULP-G, ULP-H, ULP-I, and ULP-J's background study were not affiliated to the current licensee's HFID number. LALD-B stated that none of the unlicensed staff members that worked here prior to August 1, 2021, had a background check completed under the new HFID number.	01290		

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01290	Continued From page 18 The licensee's Background Studies policy dated August 1, 2021, indicated "the [Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study has been received. [Licensee] will allow employees to have direct contact with residents while awaiting a reconsideration decision." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 8, 2023, the immediacy of correction order 1290 was removed as confirmed by evaluation supervisor review, however non-compliance remained at a scope and level of I.	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (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	01500		

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01500	Continued From page 19 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, 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	01500		

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01500	Continued From page 20 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D started employment with licensee June 21, 2021, under the comprehensive licensee and started providing assisted living services August 1, 2021. On March 7, 2023, at 9:25 a.m., ULP-D stated she could not remember if the specific training was completed as there are many other trainings completed with licensee. ULP-D's employee record lacked at least eight hours of annual training for each 12 months of employment in the following topics: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; - Infection control techniques; - Review of provider's policies and procedures;	01500		

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01500	Continued From page 21 - Principles of person-centered planning/service delivery; and - Hearing loss training (optional). On March 8, 2023, at 11:48 a.m., registered nurse (RN)-F and licensed assisted living director (LALD)-B acknowledged ULP-D's employee record was missing the required eight (8) hours of annual training for each 12 months of employment. In addition, LALD-B also stated licensee's current annual system could easily miss out individuals during their scheduled periods. In addition, LALD-B stated the licensee was changing its system of annual training to be done at one time to ensure none of the staff was missed during training. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services at licensee will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01540		

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01540	Continued From page 22 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee held a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through April 30, 2023. ULP-E ULP-E started employment with licensee January 17, 2023, providing assisted living services. ULP-E's Relias (education software) transcript indicated ULP-E had completed the following	01540		

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dementia related online courses:
- Alzheimer's Disease and Related Disorders: Behavior and ADL Management - 1 hour;
- Alzheimer's Disease and Related Disorders: Behavior Management - 1 hour;
- Alzheimer's Disease and Related Disorders: Psychosocial Care - 1 hour;
- Alzheimer's Disease and Related Disorders: The Physical Environment - 1 hour;
- Communication and People with Dementia - 1 hour;
- Dementia Care: Performing ADL's - 0.50 hours;
- Dementia Care: Preventing Catastrophic Reactions - 1 hour;
- Dementia Care: Understanding Alzheimer's Disease - 0.50 hours;
- Teepa Snow: Challenging Behaviors - 0.25 hours; and
- Teepa Snow: Dementia 101 - 0.25 hours.

ULP-E's employee record included a total of 7.50 hours for dementia training. The record lacked at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date.

On March 8, 2023, at 11:52 a.m., registered nurse (RN)-F and licensed assisted living director (LALD)-B acknowledged ULP-E's employee record was missing at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. LALD-B in addition stated licensee will audit all staff to ensure everyone has at least 8 hours of initial dementia training.

The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of the licensee are required to complete dementia training at the time of hire and annually thereafter. Also

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01540	Continued From page 24 indicated direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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	35125	A. BUILDING: _____ B. WING _____	03/08/2023

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BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(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
01620	Continued From page 25 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment monitoring no more than 14 days after initiation of services for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 started services with licensee December 19, 2022. R1's Service Plan - Addendum to Contract dated December 30, 2022, indicated R1 received the following services: bathing assistance, catheter care, compression stocking, dressing, grooming, medication administration, and monitoring and assessments. R1's record included an admission/initial assessment dated December 15, 2022, and a 14-day reassessment dated January 6, 2023. The 14-day assessment exceeded 14 calendar days from the initiation of services by 9 days. R2 started services with licensee November 14, 2022. R2's Service Plan - Addendum to Contract dated November 13, 2022, indicated R2 received the following services: dressing, deep room cleaning, bathing assistance, linen change, safety checks,	01620		

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01620	Continued From page 26 toileting, grooming, medication administration, and monitoring and assessments. R2's record included an admission/initial assessment dated November 11, 2022, and a 14-day reassessment dated December 1, 2022. The 14-day assessment exceeded 14 calendar days from the initiation of services by 7 days. R3 started services with licensee November 2, 2022. R3's unsigned service plan dated January 1, 2023, indicated R3 received the following services: bathing assistance, incontinence care, dressing, grooming, ambulation assistance, medication administration, monitoring and registered nurse (RN) assessments. R3's record included an admission/initial assessment dated November 2, 2022, and a 14-day reassessment dated December 13, 2022. The 14-day assessment exceeded 14 calendar days from the initiation of services by 27 days. On March 8, 2023, at 11:19 a.m., RN-F stated R1, R2, and R3's 14-day assessments exceeded 14 calendar days from the resident's admission dates. RN-F stated the assessment was not done timely and did not have a reason for it. The licensee's Assessment Schedules policy dated August 1, 2021, indicated ongoing client monitoring and reassessment must be conducted within 14 days after the initiation of services and at least every 90 days from the last date of assessment. No further information was provided.	01620		

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01620	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan was completed no later than 14 calendar days after the date that services are first provided for two of two residents (R1, R3). In addition licensee failed to include a signature or other authentication by the resident or resident representative and licensee to document	01640		

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01640	Continued From page 28	01640		

agreement on the services to be provided for one of three residents (R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

R1
R1 admitted to the licensee's memory care unit on December 19, 2022.

R1's Service Plan - Addendum to Contract dated December 30, 2022, indicated R1 received the following services bathing assistance, catheter care, compression stocking, dressing, grooming, medication administration, toileting and transfer assist.

R1's record indicated R1 received services from licensee's employees for 16 calendar days without a formal service plan signed by resident and/or resident representative and licensee representative of the services, frequency of services, fees and individuals who were providing services.

R3
R3 admitted to the licensee's memory care unit on November 2, 2022.

R3's unsigned service plan dated January 1, 2023, indicated R3 received the following services: bathing assistance, incontinence care,

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dressing, grooming, ambulation assistance, medication administration, monitoring and registered nurse (RN) assessments.

R3's record included an admission nursing assessment completed November 2, 2022.

R3's record indicated R3 received services from licensee's employees for 60 calendar days without a formal service plan signed by resident or resident's representative, and licensee representative for the services, frequency of services, fees and individuals that provided these services.

On March 8, 2023, at 9:55 a.m., registered nurse (RN)-F acknowledged the licensee had not executed an initial service plan with R3, before services were provided by licensee.

In addition, R3's service plans dated January 1, 2023, and February 22, 2023, respectively, lacked signatures by the facility and by the resident or the resident's representative to document authentication on the agreement for services to be provided.

On March 8, 2023, at 10:45 a.m., registered nurse (RN)-F stated the licensee had not executed a completed service plan with R1 and R3 with services received within 14-days of starting services with licensee. RN-F stated they thought the service plan was completed before giving cares.

On March 8, 2023, at 9:53 a.m., registered nurse (RN)-F stated R3's service plan at time of admission must have been missed and acknowledged that the service plans dated January 1, 2023, and February 22, 2023,

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respectively, did not get signed by either the provider, resident or resident's representative. She stated she thought the resident's representative may have brought the service plan home and not returned it. RN-F stated "she left a phone message this morning" for the resident's representative about documentation.

On March 8, 2023, at 11:30 a.m., RN-F provided surveyor with a signed service plan for R3 that was dated March 8, 2023.

The licensee's Service Plan policy dated August 1, 2021, indicated "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the residents needs and preferences. A Service Plan means the written plan between a resident or residents designated representative and the facility about the services that will be provided to the resident. Residents have the right to refuse assisted living services recommended by [Licensee]. 1. Within 14 days after the date that services are first provided to a resident, [Licensee] will finalize a written service plan. 2. The service plan and any revisions shall include a signature or other authentication by [Licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring."

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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01750	Continued From page 31	01750		
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that prior to delegating medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and the ULPs were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01750		

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01750	Continued From page 32 ULP-D ULP-D started work at the licensee's facility on June 21, 2021, under the comprehensive license and started providing assisted living services August 1, 2021. On March 6, 2023, at 12:28p.m., the surveyor observed ULP-D training ULP-K to pass medications to residents of the memory care unit. On March 7, 2023, at approximately 7:30 a.m., the surveyor and ULP-D observed the contents of the medication cart in the memory care unit where ULP-D was scheduled to pass medications. ULP-D's Competencies with a Nurse document dated September 8, 2022, lacked indication ULP-D had been trained and passed medication competency before starting to pass medications to licensee's residents. ULP-D's RELIAS transcript dated between June 23, 2021, and August 5, 2021, lacked indication ULP-D had completed medication training. On March 7, 2023, at 1:04 p.m., ULP-D stated for medication training, ULP-D shadowed another ULP for two days, completed a Relias (education software) medication administration training course, and completed quizzes. In addition, ULP-D stated the registered nurse (RN) usually checks with medication passers during their shift, and if they have questions, they ask the RN. On March 7, 2023, at 1:35 p.m., registered nurse (RN)-F stated the process for ULP medication training included a class taught by a RN, Relias course, shadow another medication passer, and	01750		

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01750	Continued From page 33 ended with a competency skills review with the RN before providing medication administration to residents. RN-F was not sure why a competency was not completed on ULP-D. RN-F stated ULP-D started before RN-F was employed with licensee. Licensed assisted living director (LALD)-B, indicated the competency review should have been completed for ULP-D. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated, "When a registered nurse or licensed health professional staff of [Licensee] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, 4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 8, 2023, the immediacy of correction order 1750 was removed as confirmed by evaluation supervisor review, however non-compliance remained at a scope and level of G.	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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01760	Continued From page 34	01760		

include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3 was admitted November 2, 2022, and had diagnoses including Parkinson's disease and Lewy Bodies dementia.

R3's service plan, dated January 11, 2022, indicated R3 received services to include assistance with medication administration.

On March 6, 2023, at 1:10 p.m., unlicensed

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01760	Continued From page 35 personnel (ULP)-E was observed to administer medications to R3. R3's medication administration record (MAR) for February 2023, indicated the following medications were administered during the month of February 2023: - quetiapine (anti-psychotic), - Rytary (for Parkinson's disease), - lisinopril (for blood pressure), - Myrbetriq (for bladder spasms), - magnesium citrate (supplement), - PEG powder (for constipation), - rivastigmine (for Parkinson's disease), and - venlafaxine (for depression). R3's record included a signed prescriber order, dated January 4, 2023, for Rytary 48.75 milligrams (mg) - 195 mg; take two capsules by mouth three times daily, and three capsules by mouth once per day. R3's February 2023 MAR indicated, Rytary 48.75 mg - 195 mg; take two capsules four times daily, and three capsules daily. The medication Rytary 48.75 mg - 195 mg was administered to R3 as two capsules four times per day. During an interview on March 8, 2023, at 11:08 a.m., registered nurse (RN)-F acknowledged prescriber orders for R3's current Rytary medication and R3's February 2023 MAR were not reconciled accurately. In addition, RN-F stated that they had communicated with R3's prescriber and requested clarification of order and new order to reflect correct number of times this medication was to be provided. On March 9, 2023, at 10:57 a.m., RN-F provided via email, the surveyor an updated order for	01760		

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01760	Continued From page 36 Rytary, dated March 8, 2023, and signed by R3's provider. The licensee's Medication and Treatment Orders policy revised August 1, 2021, indicated, "To ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. 1. The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records. Additionally, 8. A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired	01890		

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01890	Continued From page 37 medications were disposed of properly and failed to ensure a prescription drug was kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 7, 2023, at 7:38 a.m., the evaluator observed unlicensed personnel (ULP)-K pass medications in the memory care unit. On March 7, 2023, at 7:50 a.m., the evaluator and ULP-K observed the contents of the memory care unit medication cart, and the following were observed: Unlabeled medication - Antifungal powder with Miconazole nitrate 2% Expired medication - R1's refresh tears lubricant eye drops expired December 2022 On March 8, 2023, at 1:57 p.m., RN-F stated staff are trained to ensure medication are labeled and nurses audit the carts to remove and dispose expired medications monthly. No further information was provided.	01890		

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01890	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *03/06/23*
Time: 12:40:00
Report: 1013231068

Food and Beverage Establishment Inspection Report

Location:
Beehive Homes Of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN55311
Hennepin County, 27

Establishment Info:
ID #: 0039230
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634153900
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.

2-100 Supervision

2-103.11O ** Priority 2 **

MN Rule 4626.0035O The person in charge must ensure employees are informed of their responsibility to report health information about a disease that is transmissible through food.

STAFF DID NOT KNOW THE FOOD WORKER ILLNESS REPORTING REQUIREMENTS, SYMPTOMS OF ILLNESS, AND RECORD REQUIREMENTS. COMPLY WITH ABOVE RULE. PROVIDED MDH ILLNESS POLICY INFORMATION.

Comply By: 03/06/23

2-100 Supervision

2-102.12AMN

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

NO MN CFPM WAS EMPLOYED AT THE FACILITY. ONE STAFF HAD A MN CFPM THAT EXPIRED ON 9/18/22. COMPLY WITH ABOVE RULE. PROVIDED THE MN CFPM INFORMATION.

Comply By: 06/05/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

TCS FOODS (YOGURT, MILK) WERE STORED IN THE MEMORY CARE SERVICE AREA REFRIGERATOR. THE REFRIGERATOR IS RESIDENTIAL AND NOT CERTIFIED BY AN ANSI ACCREDITED PROGRAM. COMPLY WITH ABOVE RULE. DISCUSSED EQUIPMENT REQUIREMENTS.

Type: Full
Date: *03/06/23*
Time: 12:40:00
Report: 1013231068
Beehive Homes Of Maple Grove

Food and Beverage Establishment Inspection Report

Comply By: 03/07/23

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - cook line
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer - prep area
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Yogurt
Temperature: 39 Degrees Fahrenheit - Location: Memory care refrigerator
Violation Issued: No

Process/Item: Turkey
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Ham
Temperature: 38 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Milk
Temperature: 38 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Mashed potatoes
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Coleslaw
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Beans
Temperature: 138 Degrees Fahrenheit - Location: Warmer
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator D. Hinnendael.

Discussed staff illness policy, ware washing, sanitizer, date marks, serving a highly susceptible population, temperature control, cleaning, final cook temperatures, hand washing, and food handling procedures.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231068 of 03/06/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Joe Childs
Director

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