Electronically Delivered

January 14, 2025

Licensee
Windsong at Woodsedge
1010 Anne Street Nw
Bemidji, MN 56601

RE: Project Number(s) SL27160016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27160	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSONG AT WOODSEDGE	1010 ANNE STREET NW BEMIDJI, MN 56601

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27160016-0 On December 10, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 76 residents; 22 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was accurate for one of one resident (R5) whom had unsecured oxygen tanks in his sleeping unit. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's resident listing report dated December 10, 2024, indicated R5 moved into the facility on February 7, 2020. R5's current Senior Living Occupancy Agreement-Assisted Living indicated it became	0 630		

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0 630	Continued From page 2 effective on September 1, 1022, and was signed by resident on September 16, 2022. The agreement indicated R5 declined healthcare services. R5's Vulnerability Review for Residents Who are not on Services (identified as the IAPP) dated November 5, 2023, and reviewed on December 2, 2024, indicated the resident was not vulnerable for self-abuse, abuse by others or abuse to others. On December 10, 2024, from 1:00 p.m. to 3:30 p.m., on a facility tour with maintenance manager (MM)-D and lead maintenance (LM)-E, the survey engineer observed 42 oxygen cylinders stored without a storage rack or chain to secure the cylinders in the upright position in the bathroom of R5's sleeping unit. R5's IAPP dated November 5, 2023, and reviewed on December 2, 2024, was inaccurate as R5 had 42 unsecured tanks in his room, causing potential harm to self and others residing in the building. On December 10, 2024, at 3:30 p.m., licensed assisted living director (LALD)-A stated she was not aware of the oxygen tanks in his room, and an IAPP was completed. LALD-A stated if an independent resident is on oxygen the licensee does not manage the oxygen. The licensee's Resident handbook revised March 2024, indicated the following for oxygen safety: storage racks that meet state and local requirements must be used to store oxygen cylinders to prevent cylinders from tipping over. The licensee's Oxygen Safety policy dated	0 630		

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0 630	Continued From page 3 January 8, 2024, indicated in the senior living community (SCL) it is common to have residents who require continuous or intermittent oxygen in use. While the resident has this right, there are safety measures that both the resident and SLC need to adhere to for accident prevention. Cylinders must be stored in state or manufacturer approved storage containers to prevent them from tipping over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, 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	0 650		

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0 650	Continued From page 4 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (registered nurse (RN)-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 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: RN-C was hired June 28, 2022, to provide direct care services to the residents in the assisted living. RN-C's employee record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On December 12, 2024, at 10:15 a.m., LALD-A stated RN-C's annual performance reviews were not completed. LALD-A stated the licensee has been very busy with admissions and discharges and just have not had time to complete RN-C's performance reviews. The licensee's Employee Files and Information policy dated May 22, 2023, indicated employment files maintained by Human Resources are the	0 650		

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0 650	Continued From page 5 official record of all personnel actions (health records are kept in employee health). However, the policy did not include how often employee reviews would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB risk assessment annually. This had the potential to affect all	0 660		

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0 660	Continued From page 6 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated October 27, 2021, indicated the facility was at a low risk for TB transmission. On December 12, 2024, at 10:25 a.m., licensed assisted living director (LALD)-A stated the last facility TB risk assessment she could find was dated October 27, 2021, and was aware it needed to be completed annually. LALD-A stated she was unsure why it wasn't completed annually but had some nurse turnover and the TB assessment must have gotten missed. The licensee's Infection Prevention and Control Program - Assisted Living (AL) Minnesota policy dated May 23, 2024, indicated recommendation of outbreak control (detection, investigation, and control epidemic infectious diseases in the AL), are to refer to the following procedures: Annual Tuberculosis Risk Assessment. The licensee's TB Prevention and Control policy dated April 18, 2024, indicated state of Minnesota regulations require that the Assisted Living Community (ALC) must establish and maintain a comprehensive tuberculosis (TB) prevention and control program based on the most current	0 660		

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0 660	Continued From page 7 tuberculosis infection control guidelines issued by the Unites States Center of Disease Control and Prevention (CDC). The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 8 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 ensure the Emergency Preparedness Plan (EPP) was prominently posted. This had the potential to affect all residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP was not posted prominently. On December 11, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated the EPP was in the locked maintenance office and should be accessible to staff, residents, and visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 9 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 10 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one resident (R4) discharged from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's Discharge Resident Roster dated December 19, 2023, indicated R4 was admitted to the facility on July 12, 2024, and was discharged on October 17, 2024. R4's diagnoses included cerebral vascular disease. R4's progress note dated October 9, 2024, at 11:40 a.m., written by registered nurse (RN), indicated the writer was notified the resident would be moving to the [name] assisted living on October 16, 2024.	0 730		

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0 730	Continued From page 11 R4's resident record contained a record of the inventory and destruction of controlled and uncontrolled substances dated October 16, 2024. R4's record lacked a discharge summary. On December 11, 2024, at 9:28 a.m., RN-C stated she did not complete a discharge summary, but she should have completed one, and just wrote a progress note. The licensee's Resident Medical Record Documentation Requirements-Minnesota policy dated August 21, 2024, indicated the purpose of the policy was to provide a procedure for required medical documentation in Minnesota, and assist with compliance with both [name] policies and procedures and state-specified regulations. However, the policy did not address a completion of a discharge summary. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. A. A summary of the residents stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; B. A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; C. A reconciliation of all predischarge medications	0 730		

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0 730	Continued From page 12 with the resident's post discharge prescribed and over-the-counter medications; and D. A post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	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		

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	27160	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSONG AT WOODSEDGE	1010 ANNE STREET NW BEMIDJI, MN 56601

(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
0 780	Continued From page 13 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 comply with the requirements of the Minnesota State Fire Code. 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). Findings include: On a facility tour on December 10, 2024, from 1:00 p.m. to 3:30 p.m., with maintenance manager (MM)-D and lead maintenance (LM)-E, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC): CARBON MONOXIDE ALARMS/ DETECTION There were plug-in carbon monoxide alarms with a local alarm only provided in the boiler room and near the fireplace. The surveyor explained to MM-D, and LM-E, that carbon monoxide alarms are required in all	0 780		

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0 780	Continued From page 14 dwelling units and sleeping units outside and within 10 feet of all rooms used for sleeping. The surveyor further explained to MM-D, and LM-E, that an alternative to this requirement is to install carbon monoxide detectors tied into the fire alarm system in an approved location between the fuel-burning appliances and on the ceiling in the boiler room. Carbon monoxide alarms and detection systems are required and shall be installed in accordance with MSFC Section 1103, Section 915 and the local fire and building code enforcement official. EXIT DOORS The marked exit door leading from the main dining room to the exterior of the building was hard to open because it was tight at the threshold causing friction at the bottom of the door. The surveyor explained to MM-D, and LM-E, that marked exit doors are required to be maintained readily openable without excessive force in accordance with MSFC Section 1104. OXYGEN CYLINDER STORAGE There were 42 oxygen cylinders stored without a storage rack or chain to secure the cylinders in the upright position in the bathroom of resident sleeping unit 310. The surveyor explained to MM-D, and LM-E, that oxygen cylinders storage is required to comply with MSFC in Minnesota Rules Chapter 7511 and be secured to prevent the cylinder from tipping over. During the facility tour MM-D, and LM-E, verified	0 780		

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0 780	Continued From page 15 the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 16 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 required content, make the plan readily available, provide required training and drills. 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: During observation on December 10, 2024, at 12:30 p.m., the surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for all staff and occupants accessibility. The plan was located in the maintenance managers office. Maintenance manager (MM)-D, stated the office is locked when it is not occupied and there is not access to the FSEP, during times the office is locked. On December 10, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A, provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 17 The licensee provided FSEP, failed to include the following: The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on December 10, 2024, at 12:45 p.m., LALD-A, stated documentation was not available for unique and unusual needs of each residents evacuation in the event of a fire or similar emergency but they were working on it. The surveyor explained each residents unique needs for evacuation is required to be available for reference by staff in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the site specific FSEP, at least twice per year as evident by not providing documentation the required training was completed. During an interview on December 10, 2024, at 3:15 p.m., LALD-A, stated employee training was completed at on-boarding and documentation was not available for site specific FSEP training twice per year. LALD-A, also stated they will work	0 810		

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0 810	Continued From page 18 to create a new form to better document the required employee training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	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 a staff member 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 interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for three of three employees (clinical nurse supervisor (CNS)-B, maintenance manager (MM)-D, and lead maintenance (LM)-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, but was not likely to	01290		

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01290	Continued From page 19 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 the potential to affect a large portion or all of the residents). The findings include: CNS-B was hired August 24, 1988, at the campus skilled nursing facility (SNF) and was a shared employee with the assisted living facility. The licensee's Net Study 2.0 report for another entity on campus indicated CNS-B's background study was cleared July 18, 2023. MM-D was hired December 3, 1990, at the campus SNF and was a shared employee with the assisted living facility. The licensee's Net Study 2.0 report for another entity on campus indicated MM-D's background study was cleared November 17, 2003. LM-E was hired April 20, 2015, at the campus SNF and was a shared employee with the assisted living facility. The licensee's Net Study 2.0 report for another entity on campus indicated LM-E's background study was cleared March 30, 2015. On December 12, 2024, at 10:20 a.m., licensed assisted living director (LALD)-A stated the background checks should have been affiliated for CNS-B, MM-D and LM-E already, as that was completed a while back. CNS-B stated they are affiliated with the SNF on campus. The licensee's Hiring and Screening policy dated March 24, 2022, indicated transfers and shared employees who transfers to a new position/location, or employees shared between	01290		

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01290	Continued From page 20 locations may be required to have additional verifications depending on the licensure and/or background check requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days 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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01620	Continued From page 21 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnosis included atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) and hypercholesterolemia (high cholesterol). R1's Service Plan dated May 29, 2024, indicated R1 received assistance with medications, dressing, showering, laundry, and housekeeping. R1's record indicated the RN completed a 90-Day Uniform Assessment Review dated August 29, 2024, and December 10, 2024, which was 103 days in between assessments. On December 12, 2024, at 10:40 a.m., RN-C stated she was late in completing the 90-day assessment due to being busy with admissions and discharges. The licensee's Resident Medical Record Documentation Requirements-Minnesota dated August 21, 2024, indicated residents must be reassessed or reviewed by an RN on an as needed basis on changes in the residents needs	01620		

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01620	Continued From page 22 and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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01700	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident was assessed for self-administration of medications for one of one resident (R1) who self-administers creams. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnosis included atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) and hypercholesterolemia (high cholesterol). R1's Service Plan dated May 29, 2024, indicated R1 received medication assistance services. R1's electronic medication administration record (EMAR) dated December 2024 indicated the following: -betamethasone dipropionate external cream 0.05% Apply to affected areas topically as needed for inflammatory and pruritic manifestations, unsupervised self-administration twice daily; -clobetasol propionate external ointment 0.05% Apply to vulva topically as needed for dermatitis, unsupervised self-administration twice daily for itchy skin; -diclofenac sodium external gel 1 % Apply to affected areas topically as needed for moderate	01700		

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01700	Continued From page 24 pain or mild pain, unsupervised self-administration four times daily; and -ketoconazole external cream 2% Apply under breast and groin topically as needed for intertrigo (skin inflammation), unsupervised self-administration. R1's 90-Day Uniform Assessment Review dated August 29, 2024, indicated R1 will be supported to take all medications safely and as ordered. R1's record did not include an assessment to determine R1 was able to self-administer creams safely and appropriately. On December 12, 2024, at 10:40 a.m., registered nurse (RN)-C stated a self-administration assessment was not completed for R1. RN-C stated she was not sure why it was not completed but had been very busy with admissions and discharges. The licensee's Medication Administration and Supporting Processes dated December 10, 2024, indicated if a resident wishes to self-administer medications, the registered nurse will evaluate and document residents' ability to manage administration using the Self-Administration of Medical Evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 25 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 December 10, 2024, at 3:00 p.m., the surveyor and registered nurse (RN)-C observed four unsecured oxygen tanks in R2's closet in the kitchen area. RN-C stated she was unaware she had oxygen tanks, and thought she only had concentrators. RN-C stated it was most likely family brought them in when she moved in. Additionally, the surveyor and RN-C observed no oxygen sign on R2's entry door. RN-C stated the oxygen tanks should be secured and R2 should have a sign on her door since she has oxygen tanks in her room. The licensee's Oxygen Safety policy dated January 8, 2024, indicated in the senior living	02310		

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02310	Continued From page 26 community (SLC) it is common to have residents who require continuous or intermittent oxygen in use. While the resident has this right, there are safety measures that both the resident and SLC need to adhere to for accident prevention. Cylinders must be stored in state or manufacturer approved storage containers to prevent them from tipping over. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
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Type: Full
Date: *12/10/24*
Time: 12:33:34
Report: 3822241139

Food and Beverage Establishment Inspection Report

Location:
Windsong
1010 Anne Street NW
Bemidji, MN56601
Beltrami County, 04

Establishment Info:
ID #: 0023804
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Baker Park, Inc.

Phone #: 2187516211
ID #: 34449

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

OBSERVED A FEW REACH IN COOLERS WITHOUT INTERNAL THERMOMETERS. READ THESE THERMOMETERS FOR RECORDINGS ON DAILY LOG.

Comply By: 12/10/24

Surface and Equipment Sanitizers

Acid: = 700 ppm at Degrees Fahrenheit
Location: WIPING BUCKETS
Violation Issued: No

Acid: = 700 PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: <41 Degrees Fahrenheit - Location:
Violation Issued: No

Type: Full
Date: *12/10/24*
Time: 12:33:34
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Windsong

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location: ALL REACH-IN COOLERS
Violation Issued: No

Process/Item: Hot Holding
Temperature: >135 Degrees Fahrenheit - Location: PORK
Violation Issued: No

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

JOINT INSPECTION FOR HRD.

OBSERVED HAIR RESTRAINTS, HAND WASHING, PROPER GLOVE USE.

ADD SYMPTOMS TO EMPLOYEE ILLNESS LOG.

TEMP LOG IN COMPLIANCE.

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 3822241139 of 12/10/24.

Certified Food Protection Manager: Ed Harapat

Certification Number: FM8009 Expires: 10/08/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ed Harapat
Head Cook

Signed: Dave Kaufman
Dave Kaufman, RS
Environmental Health Specialist
Bemidji District Office
218-308-2100
david.kaufman@state.mn.us