Electronically Delivered

May 16, 2023

Licensee
Bethany Assisted Living In Litchfield
203 North Armstrong Avenue
Litchfield, MN 55355

RE: Project Number(s) SL23748015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23748	A. BUILDING: _____ B. WING _____	05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING IN LIT	203 NORTH ARMSTRONG AVENUE LITCHFIELD, MN 55355

(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: SL#23748015 On May 1, 2023, through May 2, 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 71 active residents; 39 receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 May 1, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 2 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 contained an annual performance review for one of one employee (unlicensed personnel (ULP)-G). 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-G had a start date of November 22, 2017, and began providing assisted living services on August 1, 2021. On May 2, 2023, at 8:34 a.m. the surveyor observed ULP-G check R1's blood glucose level	0 650		

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0 650	Continued From page 3 and administer R1's scheduled morning insulin. ULP-G's employee record did not include an annual performance review which identified areas of improvement and training needs. On May 2, 2023, at 2:10 p.m. clinical nurse supervisor (CNS)-B stated ULP-G had completed some skills testing in 2021; however, CNS-B stated she was unable to find an annual performance review in ULP-G's employee record for 2022. The licensee's Training Documentation policy dated August 1, 2021, noted performance reviews would be conducted annually at a minimum. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 4 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 5 Findings include: A record review and interview were conducted on May 2, 2023, at approximately 11:45 a.m. with Environmental Supervisor (ES)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, ES-F verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=B	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 6 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for two of two residents (R1, R3). 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	0 950		

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0 950	Continued From page 7 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1's service plan dated January 6, 2023, indicated the resident received blood glucose monitoring, medication administration, laundry, and assistance with bathing. R3's service plan dated February 17, 2023, indicated the resident received services which included blood glucose monitoring, medication administration, compression socks, catheter care, transfer assist of one with E-Z stand for all transfers, assistance with daily living (ADL), bathing, laundry, and housekeeping. R1's and R3's assisted living contract included the required verbiage regarding the resident's right to designate a representative; however, the section at the end of the assisted living contract where R1 and R3 could either identify or decline to identify a designated representative was left blank. On May 2, 2023, at 2:08 p.m. licensed assisted living director (LALD)-A reviewed R1's and R3's record and stated R1 and R3 had not been provided the opportunity to identify or decline to identify a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 8	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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 the potential to affect a large portion or all the residents). The findings include: The facility's Resident Contract (assisted living contract) and Resident and Family Handbook (considered part of the assisted living contract) were reviewed. The Resident Contract indicated in section 19. Resident Policies, Rules and Regulations "By signing this Agreement, you [resident] agree to abide by and comply with all of the Community's policies, rules and regulations,	0 970		

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0 970	Continued From page 9 which have been provided to you [resident] in the Resident Handbook. The Resident Handbook is incorporated in and considered part of this Agreement." The Resident Handbook included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page five, section Assistive Devices of the Resident Handbook indicated the owner/operator of any assistive device assumes all responsibility for damages that may result from the use or ownership of an assisted device and will hold [name of facility] harmless. The owner/operator of an assisted device will be held responsible for damage created by the assistive device to [name of facility] property. Owners/operators assume all risk of liability for damages resulting from the operation of an assisted device on or off [name of facility] premises. On May 2, 2023, at 2:05 p.m. licensed assisted living director (LALD)-A stated she could see how this language noted above waived the facility's liability. LALD-A stated the assisted living contract had been updated; however, the Resident Handbook had not been. LALD-A stated this assisted living contract and Resident Handbook were provided to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 10 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 11 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). 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) 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: R2 was admitted to assisted living services on March 17, 2018. R2's Service Plan dated January 1, 2023, indicated R2 received medication administration, laundry, bathing, meals, and housekeeping. R2's progress notes dated January 15, 2023, at 7:35 a.m., indicated R2 was sent to the emergency room after an unwitnessed fall with injury to her head. Staff called triage at 11:11 a.m., for an update and found out R2 was admitted to the hospital for positive UTI (urinary tract infection) and COVID-19. On January 23, 2023, at 3:34 p.m., R2 returned from the hospital with diagnoses including COVID-19, pneumonia,	01060		

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01060	Continued From page 12 UTI, and sepsis. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On May 2, 2023, at 10:47 a.m. clinical nurse supervisor (CNS)-B stated there was no written notice provided to R2, nor had the ombudsman been notified of R2's emergency relocation. CNS-B stated she was unaware of the emergency relocation regulation and the notifying the ombudsman. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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	23748	A. BUILDING: _____ B. WING _____	05/02/2023

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01500	Continued From page 13	01500		
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 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 14 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-G). 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:	01500		

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01500	Continued From page 15 ULP-G had a start date of November 22, 2017, and began providing assisted living services on August 1, 2021. On May 2, 2023, at 8:34 a.m. the surveyor observed ULP-G check R1's blood glucose level and administer R1's scheduled morning insulin. ULP-G's employee record did not include annual training for the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 2, 2023, at 3:24 p.m. clinical nurse supervisor (CNS)-B stated she was unable to find where ULP-G had completed the above noted annual training for 2022. The licensee's Assisted Living with Dementia Care Annual Training policy dated August 1, 2021, noted direct care staff will complete eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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	01540		

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01540	Continued From page 16 provide direct care unless there is another employee on site who has completed the initial 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 observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-G) received the required amount of annual dementia care training. 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: ULP-G had a start date of November 22, 2017, and began providing assisted living services on August 1, 2021. On May 2, 2023, at 8:34 a.m. the surveyor observed ULP-G check R1's blood glucose level and administer R1's scheduled morning insulin.	01540		

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01540	Continued From page 17 ULP-G's employee record indicated ULP-G had completed dementia care training in 2021; however, it did not include evidence annual dementia care training had been completed for 2022. On May 2, 2023, at 3:28 p.m. clinical nurse supervisor (CNS)-B reviewed ULP-G's employee record and training transcript. CNS-B stated ULP-G had not completed dementia care training as required for 2022. CNS-B stated for some reason the dementia care training modules had not been assigned to ULP-G to complete. The licensee's Dementia Training policy dated August 1, 2021, noted direct-care employees will have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only	01880		

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01880	Continued From page 18 authorized personnel for one of three medication carts (secure unit). In addition, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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: SECURITY OF MEDICATIONS On May 2, 2023, at 6:35 a.m. the surveyor observed the medication cart in the secure unit to be unlocked. The medication cart was positioned in the corner of the open living/dining room area. The surveyor observed three residents in the open living room area and the medication cart was not being monitored by any staff member at this time. At 6:39 a.m., unlicensed personnel (ULP)-F entered the secure unit, visited with a few residents, and then went down the hallway and entered a resident's room. The medication cart remained unlocked and unattended. At 6:47 a.m., ULP-F and ULP-E entered the open living/dining room area and approached the unlocked medication cart. ULP-E stated she had left the medication cart unlocked and it should have been locked. On May 2, 2023, at 7:45 a.m. clinical nurse supervisor (CNS)-B stated to keep the medications secure, the medication carts should	01880		

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01880	Continued From page 19 always be locked when not in use. STORAGE OF MEDICATIONS On May 1, 2023, at 2:36 p.m. the surveyor reviewed the medication refrigerator in the locked medication storage room with CNS-B. CNS-B stated the current temperature of the medication refrigerator was 36 degrees Fahrenheit (F). CNS-B stated the temperature of the medication refrigerator was checked daily on the night shift and recorded on a paper log. The Refrigerator Temp. Check log clipped to the front of the medication refrigerator indicated the last date the temperature was checked was April 12, 2023. The Refrigerator Temp. Check logs for April 1, 2023, through May 1, 2023, were reviewed with CNS-B. The temperature of the refrigerator had been recorded twice (April 3, 2023, and April 12, 2023) out of the 30 opportunities. The medication refrigerator contained the following medications: - 21 unopened Lantus 100 units units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R1; - 48 unopened Novolog 100 units/ml insulin pens for R1; - Seven unopened Lantus 100 units/ml insulin pens for R3; and - Six unopened Novolog 100 units/ml insulin pens for R2 The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog dated June 2021, indicated the unopened insulin	01880		

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01880	Continued From page 20 pens should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, noted medications would be handled and stored per acceptable standards. When secured storage of the medications is necessary, the registered nurse will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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 medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of four residents (R2, R4). 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	01890		

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01890	Continued From page 21	01890		

resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On May 1, 2023, at 2:35 p.m. the surveyor reviewed the locked medication carts and medication room with clinical nurse supervisor (CNS)-B. CNS-B observed and confirmed the following:
R2
R2's opened Novolog 100 units/milliliter (ml) insulin pen (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pen had been opened and when the pen would expire.

R4
R4's opened Novolog 100 units/ml insulin pen did not have an original prescription label with information regarding directions for use, resident's name, and the pharmacy in which it had been issued or a label which indicated the date the pen had been opened and when the pen would expire.

R4's Humalog mix 75/25 insulin pen did not have a label which indicated the date the pen had been opened and when the pen would expire.

On May 1, 2023, at 2:40 p.m. CNS-B stated all medications should be labeled appropriately and insulin pens should be dated when opened.

The manufacturer's instructions for Novolog dated June 2021, directed to discard the pen 28

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01890	Continued From page 22 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Humalog mix 75/25 dated November 2019, directed to discard the pen ten days after it had been opened. The licensee's Storage of Medications policy dated August 1, 2021, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 23 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 2, 2023, at approximately 11:50 a.m. with Environmental Supervisor (ES)-F on the hazard vulnerability assessment for the physical environment of the facility. During interview, ES-F verified that the licensee had not done a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures	02110		

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02110	Continued From page 24 required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia	02110		

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02110	Continued From page 25	02110		

care policies and procedures were provided to two of two residents (R1, R3) and/or the resident's legal and designated representative.

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 the potential to affect a large portion or all the residents).

The findings include:

The licensee held an assisted living with dementia care license.

R1
R1 was admitted on July 12, 2022, and resided in the secure unit.

R1's diagnoses included dementia.

R1's service plan dated January 6, 2023, indicated the resident received services which included blood glucose monitoring, medication administration, laundry, and assistance with bathing.

R3
R3 was admitted on July 12, 2022.

R3's diagnoses included fracture femur, diabetes, and Parkinson's disease.

R3's service plan dated February 17, 2023, indicated the resident received services which included blood glucose monitoring, medication administration, compression socks, catheter care,

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02110	Continued From page 26 transfer assist of one with e-Z stand for all transfers, assistance with daily living (ADL), bathing, laundry, and housekeeping. R1 and R3's record lacked evidence or documentation the resident and R1 or R3's representative received the policies and procedures related to dementia care at the time R1 and R3 moved into the facility. On May 2, 2023, at 2:00 p.m. licensed assisted living director (LALD)-A stated resident representatives have only received the Dementia Training Disclosure form which did not include all the required dementia care policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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

Type: Full
Date: *05/01/23*
Time: 11:30:00
Report: 7930231101

Food and Beverage Establishment Inspection Report

Location:
Bethany Assisted Living In Lit
203 North Armstrong Avenue
Litchfield, MN55355
Meeker County, 47

Establishment Info:
ID #: 0037732
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202212311
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

MEMORY CARE KITCHEN UPRIGHT COOLER: MILK DATED 4/23 IS PAST THE DATE AND NEEDS TO BE DISCARDED.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

LIKE STATED ABOVE IN THE COVE SERVING KITCHEN HANDWASHING SINK AND THE MEMORY CARE SERVING KITCHEN HANDWASHING SINK.

Comply By: 05/03/23

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 177 Degrees Fahrenheit - Location: MASHED POTATOES--THE COVE SERVING AREA

Violation Issued: No

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Process/Item: Steam Table
Temperature: 190 Degrees Fahrenheit - Location: PEAS--THE COVE SERVING AREA
Violation Issued: No

Process/Item: Steam Table
Temperature: 202 Degrees Fahrenheit - Location: PORK IN GRAVY--THE COVE SERVING KITCHEN

Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: AMBIENT TEMP--UPRIGHT COOLER IN THE MEMORY CARE KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK--MAIN PREP/SERVING KITCHEN
Violation Issued: No

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

ALL FOOD IN THE SERVING KITCHENS IS CATERED AND SERVED FROM THE GLORIA DEI MANOR.

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 7930231101 of 05/01/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us