Electronically Delivered

May 24, 2023

Licensee
Bethany On The Lake
1020 Lark Street
Alexandria, MN 56308

RE: Project Number(s) SL28777015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 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,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-322-5175 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
	28777	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE	1020 LARK STREET ALEXANDRIA, MN 56308

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28777015 On May 15, 2023, through May 17, 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 10 active residents; all of whom were receiving services under the Assisted Living with 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 15, 2023, at 9:51 a.m., clinical nurse supervisor (CNS)-B stated LALD-A was the current LALD for the facility. On May 15, 2023, at 9:51 a.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with CNS-B. The BELTSS website indicated LALD-A had his nursing home administrator license (effective May 26, 2016; expired October 31, 2023). In addition, the BELTSS website indicated LALD-A held a current LALD which had been issued on May 6, 2021; expired October 31,	0 110		

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0 110	Continued From page 2 2023. The website did not indicate LALD-A as the Director of Record for the licensee, this section was left blank. CNS-B stated the BELTSS website had not been updated to identify LALD-A as the Director of Record. On May 16, 2023, at 8:15 a.m., LALD-A stated he was not listed as the Director of Record on the BELTSS website. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached	0 470		

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0 470	Continued From page 3 building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the daily staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 held an assisted living with dementia care license. The facility was licensed for a capacity of 12 and had a current census of 10 residents. During the entrance conference on May 15, 2023, at 10:13 a.m., executive director (ED)-G stated the licensee had a staffing plan developed by CNS-B, licensed assisted living director	0 470		

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0 470	Continued From page 4 (LALD)-A, and licensed practical nurse (LPN)-C and was reviewed at least every six months. The surveyor requested the staffing plan, which was later provided. During the facility tour on May 15, 2023, at 10:38 a.m. the surveyor did not observe a posted daily staff schedule available to staff, residents, and visitors. CNS-B stated the two-week schedule on the clipboard, that was hanging face down on the cabinet, was available to all staff, residents and visitors to be able to review to see who was working each shift. CNS-B stated the licensee does not post a daily staff schedule. On May 16, 2023, at 2:15 p.m., the surveyor reviewed the staffing plan with ED-G. The staffing plan had a handwritten note that indicated "sufficient acuity/staffing ratio" and was signed on January 4, 2023, by LALD-A and LPN-C. ED-G stated the staffing plan should have been developed by CNS-B. The licensee's Assisted Living Staffing and Scheduling policy dated August 1, 2021, indicated the CNS will develop and implement a written staffing plan that will be addressed, at a minimum, bi-annually by the CNS. The policy also indicated a daily 24 hour staff schedule will be posted in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 5 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 16, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that 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	0 680		

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0 680	Continued From page 6 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prominently post a written emergency preparedness plan (EPP). In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of 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), 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:	0 680		

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0 680	Continued From page 7 EPP On May 15, 2023, at 10:38 a.m., during the facility tour with clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C, the surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. On May 15, 2023, at 3:30 p.m., CNS-B stated the EPP was not posted in the common area of the facility and was placed in a cabinet not visible to staff, residents, or visitors. MISSING RESIDENT PLAN On May 15, 2023, at 3:28 p.m., the licensee's Code White- Missing Resident policy, dated September 2022, was reviewed with CNS-B. CNS-B stated the policy was last reviewed September 2022 and had not been reviewed quarterly, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
01290 SS=C	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	01290		

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01290	Continued From page 8 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter with the correct affiliation for the assisted living facility for two of three employees (unlicensed personnel (ULP)-D, ULP-E). 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). ULP-D ULP-D was hired on September 6, 2018, and had begun providing assisted living services on August 1, 2021. On May 16, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license.	01290		

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01290	Continued From page 9 ULP-E ULP-E was hired August 6, 1982, and had begun providing assisted living services on August 1, 2021. On May 16, 2023, at 7:53 a.m., the surveyor observed ULP-E conduct a blood glucose check on R3. ULP-E's record lacked documentation of a cleared background study affiliated with the facility's license. On May 16, 2023, at 1:05 p.m., human resource director (HR)-H stated the employees identified above were currently employed by the facility and the affiliation for the employee's background studies were affiliated with the entire campus (nursing home, assisted living and adult day services). HR-H stated the only staff with the correct affiliation on the background study would have been licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and owners of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being	01440		

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01440	Continued From page 10 performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel ((ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01440		

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01440	Continued From page 11 ULP-D was hired on September 6, 2018, and had begun providing assisted living services on August 1, 2021. On May 16, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On May 16, 2023, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated there was not a 30 day supervision on any delegated tasks for ULP-D by the RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of	01640		

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01640	Continued From page 12 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan was revised to reflect the current identification of staff who will provide the services for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a client'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 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: R3 R3's diagnoses included type two diabetes, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, and hypertension (high blood pressure).	01640		

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01640	Continued From page 13 On May 16, 2023, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-E conduct a blood glucose check on R3. R3's Registered Nurse (RN) Assessments dated March 3, 2023, and March 17, 2023, respectively, indicated clinical nurse supervisor (CNS)-B completed both assessments. R3's service plan dated April 1, 2023, indicated mandatory assessments done every 90 days were completed by the licensed practical nurse (LPN). R4 R4's diagnoses included hypertension, muscle weakness, aphasia (loss of ability to understand or express speech), and major depressive disorder. On May 16, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. R4's RN Assessments dated December 13, 2022, and March 7, 2023, respectively, indicated CNS-B completed both assessments. R4's service plan dated January 1, 2023, indicated mandatory assessments were completed quarterly by the LPN. On May 17, 2023, at 9:21 a.m., executive director (ED)-G stated the assessments were completed by an RN and should be reflected on the service plan. The licensee's Service Plan policy dated November 2019, indicated the service plan will	01640		

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01640	Continued From page 14 identify the type of staff that will provide the service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content 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 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: During the entrance conference on May 15, 2023, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services, however, did not offer	01770		

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01770	Continued From page 15 medication set ups. On May 15, 2023, at 10:54 a.m., during review of the licensee's medication cart, the surveyor observed four syringes of pink liquid placed in R2's original morphine sulfate (a moderate to severe controlled substance pian reliever) medication box. Licensed practical nurse (LPN)-C stated she drew up the four syringes containing morphine sulfate for unlicensed personal (ULP) to administer as needed to R2. LPN-C stated she did not document the medication set up, however placed an entry in the task tab of the resident's electronic record. R2's diagnoses included dementia, peripheral edema (swelling of extremities) and acute cerebrovascular accident (stroke). R2's service plan dated April 21, 2023, indicated the resident received medication administration services. R2's prescriber order dated April 27, 2023, included an order for morphine 100 milligrams (mg)/5 milliliters (mL) take 0.25 mL by mouth every four hours if needed for moderate pain, comfort care or shortness of breath. R2's Service Single Service Task dated April 28, 2023, had written "4 Syringes Morphine Sulfate prn/pain/SOB per hospice fill by nurse 0.25 ml each. Added medication box in narc box [sic]." R2's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, quantity of dose, times to be administered, route of administration and name of person completing medication setup for R2's	01770		

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01770	Continued From page 16 morphine sulfate. On May 15, 2023, at 3:27 p.m., CNS-B stated the medication set up documentation for R2 did not have all the required content. The licensee's Medication Administration-Documentation policy dated November 2019, indicated when a licensed nurse sets up medications will observe and monitor the past week's medication administration documentation and compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 17 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 18 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-D) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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: During the entrance conference on May 15, 2023, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services. ULP-D was hired on September 6, 2018, and had begun providing assisted living services on August 1, 2021, which included medication administration. On May 16, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D's employee record lacked evidence to indicate ULP-D had been trained and demonstrated competency to provide	01790		

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01790	Continued From page 19 medications to residents for unplanned times away from home. On May 16, 2023, at 2:20 p.m., CNS-B stated ULP-D had not been trained or deemed competent to prepare and give medications to residents for an unplanned time away. CNS-B stated no ULPs at the facility had been trained or deemed competent to prepare and give medications to residents for an unplanned time away. The licensee's Medication Administration-Planned and Unplanned Time Away policy dated November 2019, indicated for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested ULP may give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 20 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for one of one resident (R5). In addition, the licensee failed to monitor for expired medications in the licensee's stock medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: During the entrance conference on May 15, 2023, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. DATING TIME SENSATIVE MEDICATIONS On May 16, 2023, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-E return to the medication cart after completing R5's blood glucose check and administration of insulin. R5's Levemir 100 units/milliliters (mL) pen (a multiple dose pen shaped injector device for insulin administration) was not labeled with the open date and ULP-E was not sure when the pen was opened. ULP-E stated when a new pen is opened it should be labeled. Licensed practical nurse (LPN)-C stated the pen should have been	01890		

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01890	Continued From page 21 labeled with the open date. On May 16, 2023, at 9:27 a.m., CNS-B stated insulin pens should be labeled with the open date. The manufacturer's instructions for Levemir insulin pens dated January 2019, directed to discard the pen 42 days after it had been opened, even if it still had insulin left in it. EXPIRED MEDICATIONS On May 15, 2023, at 10:50 a.m., the surveyor toured the facility with CNS-B and LPN-C including a review of the locked medication cart. LPN-C confirmed the following: -opened stock ClearLax bottle expired December 2022. On May 15, 2023, at 10:50 a.m., CNS-B stated expiration dates should be checked prior to medication administration. The licensee's Labeling of Medication policy dated December 2019, indicated medications such as insulin pens should be labeled with the date opened. The licensee's Disposal of Medication policy dated August 1, 2021, indicated any expired medication managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01900 SS=F	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription drug supply for three of three residents (R2, two unknown residents) were not saved for use by anyone other than the resident for which the medication was prescribed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, at 10:50 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C including a review of the locked medication cart. The following were observed amongst the stock medication in the bottom drawer of the medication cart: - one opened bottle of Miralax with a prescription label intact and directions to take 17 grams with four ounces of water daily as needed. The resident name on the prescription bottle was blackened out with a marker and stock was handwritten on the bottle, however, LPN-C stated she could read the name and the medication was	01900		

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01900	Continued From page 23 prescribed for R1 who had been discharged [R1's discharge records indicated R1 had been discharged on February 22, 2023]; - one opened bottle of Miralax with a pharmacy label, which was mostly removed from the bottle and stock was handwritten on the bottle; and -one opened bottle of milk of magnesia with a pharmacy label, which was mostly removed from the bottle and stock was handwritten on the bottle. On May 15, 2023, at 10:50 a.m., CNS-B stated the medication bottles noted above had been prescribed for specific residents and the labels on the bottles had been partially removed or altered and someone placed them in the stock medication drawer of the medication cart. CNS-B stated medications prescribed for one resident cannot be used for another resident. The licensee's Disposal of Medication policy dated August 1, 2021, indicated unused medications managed by the assisted living provider will be returned to the pharmacy for credit, or give to the client or the client's representative, when the client's medications are no longer managed by the assisted living provider, or the medication has been discontinued by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910		

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01910	Continued From page 24 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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:	01910		

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01910	Continued From page 25 During the entrance conference on May 15, 2023, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. The licensee's Discharged or Deceased Resident Roster, dated May 15, 2023, indicated R1 was admitted on January 10, 2023, and discharged on February 22, 2023. R1's diagnoses included breast cancer, generalized anxiety disorder, depression, and constipation. R1's service plan dated February 6, 2023, indicated R1 received medication administration services. R1's Medication Administration Record (MAR) for January 2023, indicated the resident received the following medications: -acetaminophen (pain reliever) 1,000 milligrams (mg) twice daily -furosemide (diuretic) 40 mg daily -levothyroxine sodium (to treat thyroid levels) 88 micrograms (mcg) daily -lorazepam (treat anxiety) 2 mg/milliliter (mL) 0.25 mL every night -metoprolol tartrate (treat high blood pressure) 25 mg twice daily -MS Contin (pain reliever) 15 mg twice daily -omeprazole (acid reflux) 20 mg daily -potassium chloride (treat low potassium levels) 10 milliequivalent (mEq) daily -Senna Plus (treat constipation) 8.6-50 mg two tablets twice daily -sertraline (depression) HCl 100 mg daily -Miralax (treat constipation) 17 grams (gm) with	01910		

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01910	Continued From page 26 four ounces of water daily as needed R1's prescriber orders dated February 10, 2023, included the above noted medications. R1's Progress Notes dated February 22, 2023, at 10:22 a.m., indicated the resident passed away at 6 a.m. today (February 22, 2023). R1's record lacked documentation for the disposition of the following medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition: -acetaminophen 1,000 mg -furosemide 40 mg -levothyroxine sodium 88 mcg -metoprolol tartrate 25 mg -omeprazole 20 mg -potassium chloride10 mEq -Senna Plus 8.6-50 mg -sertraline HCl 100 mg -Miralax 17 gm On May 15, 2023, at 2:52 p.m., CNS-B stated the disposition of medications for R1 were lacking the above noted medications. The licensee's Disposal of Medication policy dated August 1, 2021, indicated upon disposition, the licensee must document in the record the disposition of the medication including the name, strength, prescription number as applicable, quantity, date of disposition and other individuals involved in the disposition. No further information provided.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28777	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE	1020 LARK STREET ALEXANDRIA, MN 56308

(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
01910	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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. 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).	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28777	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE	1020 LARK STREET ALEXANDRIA, MN 56308

(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
02040	Continued From page 28 The findings include: A record review and interview were conducted on May 16, 2023, at approximately 11:50 a.m. with licensed practical nurse (LPN)-C on the hazard vulnerability assessment for the physical environment of the facility. During interview, LPN-C 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		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *05/16/23*
Time: 11:00:53
Report: 1008231005

Food and Beverage Establishment Inspection Report

Location:
Bethany On The Lake
1020 Lark Street
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0037726
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207631133
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.

4-500 Equipment Maintenance and Operation

4-501.110 ** Priority 2 **

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

MAINTAIN A TEMPERATURE LOG FOR THE UNDER COUNTER DISH WASHER.

Comply By: 05/17/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC KITCHEN. KITCHEN IS BEING USED AS A SERVICE KITCHEN ONLY. THE DOMESTIC COOLER IS CURRENTLY HOLDING TCS FOODS. TCS FOODS CAN NOT BE HELD FOR MORE THAN 24 HOURS WITHIN THE DOMESTIC COOLER.

Comply By: 05/17/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CHEESE
Violation Issued: No

Type: Full
Date: *05/16/23*
Time: 11:00:53
Report: 1008231005
Bethany On The Lake

Food and Beverage Establishment Inspection Report

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

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 1008231005 of 05/16/23.

Certified Food Protection Manager: Lynnette A Malvin

Certification Number: FM99977 Expires: 07/26/25

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us