DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 5, 2024

Licensee
Bethel Pavilion Homecare LLC
7535 Douglas Drive North
Brooklyn Park, MN 55443

RE: Project Number(s) SL37682015

Dear Licensee:

On December 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 5, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

October 31, 2023

Licensee
Bethel Pavilion Homecare, LLC
7535 Douglas Drive North
Brooklyn Park, MN 55443

RE: Project Number(s) SL37682015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 5, 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 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37682	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL PAVILION HOMECARE LLC	7535 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443

(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: SL37682015-0 On October 2, 2023, through October 5, 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 was one active resident who received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents and potential residents searching for appropriate assisted living placement. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 430		

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0 430	Continued From page 2 The licensee's UDALSA, last updated April 21, 2022, indicated on page two, under General Information, that licensed staff are either in the building, an attached building, or within the campus and available to respond to resident requests 24/7. In addition, on page eleven, the UDALSA indicated the licensee provided a wander alert system at facility exits, noting an alarm system alerts when exit doors are open in the comments section. On page twelve, the UDALSA indicated there were door sensors, in the comments section it was specified the door sensors were located at the front door and garage door. Page sixteen of the UDALSA indicated a licensed practical nurse was on site part-time. Page seventeen indicated the house contained four one-bedroom units. Page eighteen indicated there was a laundry room accessible to residents. On October 3, 2023, at 1:00 p.m., the clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they completed UDALSAs for three houses and some of the information may have incorrectly carried over. CNS/LALD-A confirmed this location was not part of a campus and licensed staff were not available on site 24/7. CNS/LALD-A stated the registered nurse (RN) was available by phone 24/7 and would come on-site when needed. CNS/LALD-A stated this facility did not have an alarm system at any doors, there were no LPNs on staff, and there were five bedrooms in the house available for residents. CNS/LALD-A stated the lower-level laundry room would not be accessible to residents unless they were able to walk down the stairway to the lower part of the split-level entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		

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0 660	Continued From page 3	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. In addition, the licensee failed to complete TB testing upon hire for two of three employees (clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A, unlicensed personnel (ULP)-B). 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	0 660		

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0 660	Continued From page 4 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed August 1, 2021, and indicated the facility was at a low risk for TB transmission and the licensee would conduct or update the TB risk assessment annually. The licensee lacked an updated TB risk assessment. CNS/LALD-A CNS/LALD-A was hired on August 1, 2021, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS/LALD-A's employee record included annual completed health history and symptom screening, record of annual TB training, and result of serum blood test for TB from January 30, 2019. CNS/LALD- A's record lacked baseline TB testing completed on or within ninety days prior to their hire date with licensee. ULP-B ULP-B was hired on March 28, 2023, to provide direct services to residents. ULP-B's employee record included annual completed health history and symptom screening and record of annual TB training. ULP-B's record lacked baseline TB screening. On October 3, 2023, at 3:30 p.m., CNS/LALD-A stated they had not done TB testing on any staff that had initially been tested for working at their	0 660		

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0 660	Continued From page 5 original facility that was under a different health facility identification number (HFID). The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening to provide a basis for comparison in the event of exposure, and to reduce the risk to others. The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated August 1, 2021, indicated the facility would perform a facility risk assessment on an annual basis. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2021, indicated the LALD was responsible for conducting the formal TB Risk Assessment and updating it annually. In addition, baseline testing would be completed for all direct care providers and anyone who visits residents including volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 7 The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; - consideration for alternate sources of energy to maintain temperatures to protect resident health/safety; safe/sanitary storage of provisions; emergency lighting; fire detection, extinguishing, alarm systems; and sewage and waste disposal; - developed policy/ procedure (p/p) to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - developed p/p to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - written communication plan containing all required elements; - documented EP training and testing program; - p/p to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; and - names, primary, and alternate contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers. On October 2, 2023, at 1:54 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)- A stated a review of the Missing Resident Policy occurred every six months to one year. The emergency preparedness binder contained a review log indicating all policies within the binder were established on August 1, 2021, and reviewed on the following dates by CNS/LALD-A: March 9, 2022; September 9, 2022; and March 9, 2023. CNS/LALD-A stated the binder had been a work in progress and they	0 680		

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0 680	Continued From page 8 would update anything that was missing. The licensee's Emergency Preparedness policy dated August 1, 2023, indicated the facility would put together a detailed emergency procedure plan to mitigate, protect against, respond to, and recover from threats and hazards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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. (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	0 810		

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0 810	Continued From page 9 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 the 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). Findings include: A record review and interview were conducted on October 6, 2023, at approximately 2:00 p.m. with the certified nurse supervisor/ licensed assisted living director (CNS/LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, CNS/LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, CNS/LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. 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 the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, CNS/LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. Licensee was providing training at the same time as the evacuation drills, and using a	0 810		

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0 810	Continued From page 11 third-party online program to provide general fire safety education. Training of employees must be specific to the facility plan. During interview, CNS/LALD-A verbally confirmed the findings. 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 including movement, evacuation, or relocation as required by statute. During interview, CNS/LALD-A stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were conducted in April and May of 2023, but not completed every other month and failed to provide two drills on each shift. During interview, CNS/LALD-A verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any	0 820		

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BETHEL PAVILION HOMECARE LLC	7535 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443

(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
0 820	Continued From page 12 existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedroom # 3, #4, and #5 with the minimum window opening meeting the minimum state standard for egress. 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). The findings include: On October 3, 2023, approximately from 1:30 p.m. to 2:30 p.m., survey staff toured the facility with the certified nurse supervisor/ licensed assisted living director (CNS/LALD)-A. At approximately 1:35 p.m., survey staff asked CNS/LALD-A to open the window in occupied resident bedroom #3 on the lower level for measurement. CNS/LALD-A opened the window	0 820		

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0 820	Continued From page 13 and measured the clear opening to be 32.5 inches in height and 18 inches in width with a total openable area of 585 square inches. The window did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. At approximately 1:45 p.m., survey staff asked CNS/LALD-A to open the window in occupied resident bedroom #4 on the lower level for measurement. CNS/LALD-A opened the window and measured the clear opening to be 32.5 inches in height and 17.75 inches in width with a total openable area of 577 square inches. The window did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. At approximately 1:55 p.m., survey staff asked CNS/LALD-A to open the window in occupied resident bedroom #5 on the lower level for measurement. CNS/LALD-A opened the window and measured the clear opening to be 32.5 inches in height and 17.5 inches in width with a total openable area of 560 square inches. The window did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. Survey staff explained to CNS/LALD-A that at least one window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. CNS/LALD-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable	0 820		

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0 820	Continued From page 14 area (4.5 square feet) for the window. No Further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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:	0 910		

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0 910	Continued From page 15 The licensee lacked a written contract with the following required content: - the health facility identification (HFID) of the facility. R1's Assisted Living Contract, dated July 17, 2023, included the legal name of the facility, the name, telephone number, and physical mailing address, the managing agent of the facility, and the authorized agent for the facility; however, lacked the correct health facility identification of the facility. On October 5, 2023, at 1:43 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated the contract should include the correct HFID and would need to be modified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the 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;	01060		

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01060	Continued From page 16 (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 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 required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

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01060	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 31, 2023, and began receiving assisted living services. R1's Service Plan - Addendum to Contract signed July 17, 2023, indicated R1 received assistance with dressing, grooming, bathing, toileting, incontinence care, transfers, housekeeping, laundry, meals, and medication administration. R1's discharge documents from Regions Hospital, dated July 17, 2023, indicated R1 was inpatient at Hennepin County Medical Center beginning on July 14, 2023, with a discharge date of July 17, 2023. R1's Assessment, dated July 17, 2023, indicated R1 had returned to licensee on July 17, 2023, following an inpatient stay at Regions Hospital. R1 was admitted to Regions Hospital on July 14, 2023, and treated for a urinary tract infection. R1's record lacked a written notice delivered to the resident or designated representative 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 OOLTC; - if known and applicable, the approximate date	01060		

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01060	Continued From page 18 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 - 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. On October 4, 2023, at 3.22 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/ LALD)- A stated R1's record lacked a written emergency relocation notice. CNS/LALD-A stated they were unaware of the required emergency relocation process and ombudsman notification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test.	01320		

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01320	Continued From page 19 Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment with licensee on June 26, 2023. R1's Service Recap Summary, dated September 1 through September 30, 2023, indicated on twenty shifts during the month, ULP-C signed off on performing the following tasks for R1: assisted with ambulation, bathing, exercise program, grooming, glasses care, incontinence care, nail care, prosthetic device, transfers, toileting, and measuring vital signs. ULP-C's record lacked the following training and competency evaluations: - reports of changes in the resident's condition to	01320		

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01320	Continued From page 20 the supervisor designated by the assisted living provider; and - standby assistance techniques and how to perform them. On October 5, 2023, at 12:40 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)- A stated the content of the missing training was contained on one education module. Upon reviewing ULP-C's transcript for online education, CNS/LALD- A stated the required course was missed when ULP-C's training was assigned. The licensee's Staff Competency policy, dated August 1, 2021, indicated the above missing content would be included in training prior to performing tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides	01330		

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01330	Continued From page 21 or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required competencies were completed for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment with licensee on June 26, 2023, providing direct care services to the licensee's residents. R1's Service Recap Summary, dated September 1 through September 30, 2023, indicated on twenty shifts during the month, ULP-C signed off on performing the following tasks for R1: assisted with ambulation, bathing, exercise program, grooming, glasses care, incontinence care, nail care, prosthetic device, transfers, toileting, and measuring vital signs. ULP-C's employee record lacked documentation	01330		

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01330	Continued From page 22 of completed competencies for the following: - observation, reporting, and documenting of resident status. On October 5, 2023, at 12:40 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)- A stated the content of the missing training was contained on one education module. Upon reviewing ULP-C's transcript for online education, CNS/LALD- A stated the required course was missed when ULP-C's training was assigned. The licensee's Staff Competency policy, dated August 1, 2021, indicated the above missing content would be included in training prior to performing tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
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 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	01440		

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01440	Continued From page 23 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on June 26, 2023, to provide direct care services to residents of the facility. R1's Service Recap Summary for July 2023, indicated ULP-C assisted R1 with ambulation, transfers, bathing, grooming, toileting, exercise program, and application of ankle foot prosthetic device on nineteen out of thirty-one dates.	01440		

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01440	Continued From page 24 R1's Med Admin Summary for June 2023, indicated ULP-C began preparing and administering medications for R1 on June 27, 2023, by ULP-C signing off on medication administration for R1. ULP-B's Home Health Aide Competency Evaluation Detail dated August 26, 2023, indicated a RN supervised ULP-C on August 26, 2023, or sixty-one days after hire, while giving a shower. ULP-B's record lacked evidence a RN conducted direct supervision of ULP-C within 30 days of performing delegated tasks, as required. Additionally, the supervision did not include an observation of the staff administering medications as required for staff who perform medication administration. On October 4, 2023, at 2:18 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they were there onsite and observed ULP-C provide cares during ULP-C's first thirty days but did not document it as a supervisory visit. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated the RN would provide direct supervision of ULPs performing delegated tasks within thirty days after the ULP began working for the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 25 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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	37682	A. BUILDING: _____ B. WING _____	10/05/2023

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01470	Continued From page 26 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 the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired June 26, 2023, to provide direct care services to residents.	01470		

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01470	Continued From page 27 ULP-C's employee record lacked the following required orientation content to be completed before providing assisted living services to residents: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. The orientation content above was completed between July 5, 2023, and July 31, 2023. R1's Med Admin Summary for June 2023, indicated ULP-C began preparing and administering medications for R1 on June 27, 2023, by ULP-C signing off on medication administration for R1. R1's Service Recap Summary for July 2023, indicated ULP-C assisted R1 with ambulation, transfers, bathing, grooming, toileting, exercise program, and application of ankle foot prosthetic device on nineteen out of thirty-one dates. On October 4, 2023, at 2:18 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated their process was to make sure the background study and tuberculosis testing were complete and then get unlicensed	01470		

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01470	Continued From page 28 personnel working in the house to keep them motivated. CNS/LALD-A stated they were aware they did not always complete the required items before starting staff and stated they pick and choose the learning modules they want to complete and don't always get the right ones done first. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all assisted living employees must complete the orientation education requirements before providing direct care services to a resident and annually thereafter. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 29 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing reassessments not to exceed ninety calendar days from the last date of assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan - Addendum to Contract signed July 17, 2023, indicated R1 received assistance with dressing, prosthetic device, grooming, bathing, toileting, incontinence care, transfers, housekeeping, laundry, meals, and medication administration. R1's record indicated the RN completed an admission assessment on March 31, 2023, and a 14-day assessment on April 14, 2023. An ongoing assessment was due by July 13, 2023. The	01620		

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01620	Continued From page 30 record lacked an ongoing assessment completed by July 13, 2023. On October 2, 2023, at 2:52 p.m., CNS/LALD-A presented the surveyor with a fall report for R1. The report indicated R1 had tried to get up from his wheelchair on his own and had fallen on July 14, 2023, at 4:30 p.m. At the time of the fall the report indicated R1 had a body temperature of 101.4 degrees. CNS/LALD-A's documentation indicated that R1 had "been running a low-grade temperature for the last three days". The documentation indicated CNS/LALD-A was at the facility and called 911 and R1 was transported to Regions Hospital at approximately 6:00 p.m. Regions Hospital Discharge Orders, dated July 17, 2023, indicated R1 was admitted on July 14, 2023, with a diagnosis of urinary tract infection, treated, and discharged back to licensee on July 17, 2023. CNS/LALD-A completed a change of condition assessment when R1 returned to licensee on July 17, 2023. On October 4, 2023, at 2:18 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they complete assessments before admission, at admission, at 14 days, 90 days, and when there is a change in condition. The licensee's Assessment and Reassessment policy dated August 1, 2023, indicated ongoing resident reassessments must be conducted by a registered nurse (RN) and cannot exceed ninety days for the last date of assessment. No further information was provided.	01620		

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01620	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all prescribed medications were maintained available in the facility medication supply for use as needed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01760		

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01760	Continued From page 32 The findings include: R1 was admitted to the licensee on March 31, 2023, and began receiving assisted living services. R1's diagnoses included traumatic brain injury (TBI), paranoid schizophrenia, anxiety, antisocial personality disorder, cervical degeneration, major depression, pain, reversible disease of blockage in breathing passages, auditory hallucination, history of alcohol and drug abuse, and history of seizures. R1's Service Plan - Addendum to Contract signed July 17, 2023, indicated R1 received medication administration. R1's Individualized Medication Management Plan, dated July 17, 2023, indicated the licensed nurse would be responsible for monitoring and reordering medication supplies as needed. R1's signed Physician Standing Orders dated March 31, 2023, included orders for: - acetaminophen 650 milligram (mg), one tablet or suppository every four hours as needed for temperature over 99.9 degrees or pain; - over the counter (OTC) antacid by mouth every four hours as needed for heartburn or epigastric distress: may use Tums, Rolaids, or Maalox according to label directions; - OTC cough drops, Robitussin, or Tussex by mouth every four hours as needed for cough according to label directions; - OTC antidiarrheal medication by mouth after each loose stool as needed: may use Imodium according to label directions; - OTC laxative by mouth or suppository every day	01760		

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01760	Continued From page 33 as needed for constipation: may use Milk of Magnesia or glycerin suppository according to label directions; and - antibiotic ointment to minor cuts and scrapes. On October 4, 2023, at 10:30 a.m., the surveyor observed the medication cabinet to lack supply of all above ordered medications for R1. On October 4, 2023, at 10:30 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they obtained the order in case the medications were needed but had not obtained the medication supply. The licensee's Medication Supply policy dated August 1, 2021, indicated licensee would ensure resident had the appropriate supply of medications as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 store all medications in a securely locked location for one of one resident (R1).	01880		

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01880	Continued From page 34 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 31, 2023, and began receiving assisted living services. R1's diagnoses included traumatic brain injury (TBI), paranoid schizophrenia, anxiety, antisocial personality disorder, cervical degeneration, major depression, pain, reversible disease of blockage in breathing passages, auditory hallucination, history of alcohol and drug abuse, and history of seizures. R1's Service Plan - Addendum to Contract signed July 17, 2023, indicated R1 received assistance with dressing, grooming, bathing, toileting, incontinence care, transfers, housekeeping, laundry, meals, and medication administration. R1's Individualized Medication Management Plan (IMMP) dated July 17, 2023, indicated all of R1's medications were administered by staff and securely stored in the locked medication cabinet. In addition, the IMMP indicated R1 had been deemed unable to safely self-administer any medications due to history of mental health that might interfere with their decision making.	01880		

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01880	Continued From page 35 On October 4, 2023, at 10:30 a.m., the surveyor observed a container of zinc oxide cream in the upstairs bathroom cabinet. The cabinet was not locked and was accessible to R1, staff, and any visitors to the facility. On October 4, 2023, at 10:30 a.m., the clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated the zinc oxide was applied topically to R1's peri area and applied in R1's bedroom or the bathroom, therefore was kept in the bathroom cabinet for convenience. CNS/LALD-A stated it was not specified in the IMMP for any medications to be stored outside of the medication cabinet. The licensee's policy Storage/ Control of Medications dated August 1, 2021, indicated all medications managed and stored by licensee would be kept securely locked and only accessible by authorized staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must	01940		

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01940	Continued From page 36 contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one or one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01940		

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01940	Continued From page 37 R1 R1 was admitted to the licensee on March 31, 2023, and began receiving assisted living services. R1's diagnoses included traumatic brain injury (TBI), paranoid schizophrenia, anxiety, antisocial personality disorder, cervical degeneration, major depression, pain, auditory hallucinations, history of alcohol and drug abuse, and history of seizures. R1's Service Plan - Addendum to Contract signed July 17, 2023, indicated R1 received assistance with prosthetic device, dressing, grooming, bathing, toileting, incontinence care, transfers, housekeeping, laundry, meals, and medication administration. On October 4, 2023, at 1:35 p.m., the surveyor observed R1 wearing a prosthetic device on his left foot. Unlicensed personnel (ULP)-B demonstrated removal and application of the prosthetic device to the surveyor. ULP-B stated they apply the prosthetic device in the morning, remove and apply it in the afternoon, and remove it at bedtime. R1's treatment and/or therapy management plan failed to include: - statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 38 - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 5, 2023, at 10:30 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)- A stated they thought there were detailed instructions included in the service plan. Upon looking for the detailed instructions, CNS/LALD-A was unable to locate them in the service plan or individual treatment therapy management plan. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN would prepare an individualized treatment or therapy management plan for each resident that received prescribed treatments. The plan would address the specific items noted above. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090		

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BETHEL PAVILION HOMECARE LLC	7535 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443

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03090	Continued From page 39 subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at each entry way of the facility to display statutory language to disclose the potential for electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, at 10:30 a.m., upon entering the facility, the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On October 3, 2023, at 3:07 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-A stated they had not posted the electronic monitoring notice because they did not have any cameras in place. CNS/LALD-A stated they understood that since monitoring could be initiated by anyone that came into the house without disclosure the sign should still be posted at the facility entrances. The licensee's Electronic Monitoring policy, dated August 1, 2021, indicated the licensee would post a sign at each facility entrance that states,	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37682	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL PAVILION HOMECARE LLC	7535 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443

(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
03090	Continued From page 40 "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/02/23*
Time: 13:38:01
Report: 103923115

Food and Beverage Establishment Inspection Report

Location:
Bethel Pavilion Homecare Llc
7535 Douglas Drive North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038646
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635013737
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Peggy Anderson

The establishment has a residential kitchen and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, laminate floor, a mix of painted or decorative tile walls and painted popcorn ceiling.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

A residential dish machine is located in the kitchen and the person-in-charge states the dish machine utensil surface temperature reaches 165 degrees F. A waterproof irreversible thermometer is present.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods.

Type: Full
Date: *10/02/23*
Time: 13:38:01
Report: 103923115
Bethel Pavilion Homecare Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 103923115 of 10/02/23.

Certified Food Protection Manager: Lydia L. Oyewole

Certification Number: FM110109 Expires: 01/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Lydia L. Oyewole
Person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us