Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 15, 2024

Licensee
Bella Vie Living LLC
7001 Emerson Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36107015

Dear Licensee:

On July 22, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 24, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

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May 16, 2024

Licensee
Bella Vie Living LLC
7001 Emerson Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL36107015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

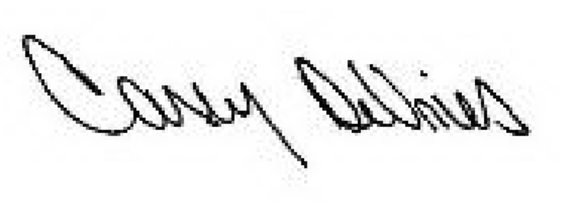
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36107	A. BUILDING: _____ B. WING _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VIE LIVING LLC	7001 EMERSON AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#36107015-0 On April 22, 2024, through April 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents all of whom received services under the provider's Assisted Living license. An immediate order was issued on April 23, 2024, for tag identification number 0820. The immediacy was not lifted at the time of exit on April 24, 2024.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470		

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0 470	Continued From page 2 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 April 22, 2024, at 9:48 a.m., during the entrance conference, CNS-A stated the licensee had a staffing plan and that it was updated daily. The surveyor requested to review the staffing plan after the entrance conference. On April 22, 2024, at 11:50 a.m., the surveyor requested to review licensee's staffing plan. CNS-A stated it was licensee's understanding that the daily staffing schedule served the same purpose as a staffing plan, and it was reviewed daily. The licensee's Staffing policy dated January 5, 2023, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. The policy also indicated the staffing plan determined the required staffing level. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 3 (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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 4 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. 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: On April 22, 2024, at 10:55 a.m., during the facility tour, the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of the grievance procedure to include the name, telephone number and e-mail contact information for the	0 550		

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0 550	Continued From page 5 individuals who were responsible for handling resident grievances. On April 22, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-A stated the grievance procedure was posted and probably was hidden with other documents. On April 24, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee thought all posting requirements were met. CNS-A also stated the licensee was not aware of this requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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.	0 660		

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0 660	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB screening for two of two employees (unlicensed personnel (ULP)-C, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment tool dated March 13, 2024, indicated the licensee was at low risk for TB. ULP-C ULP-C was hired on August 24, 2023. ULP-C's record included a T-SPOT (R) TB test dated July 9, 2023, with a negative result. ULP-C's record lacked TB history and symptom screen completed at hire. ULP-D ULP-D was hired on April 3, 2023. ULP-D's record included a QuantiFERON-TB gold plus test dated May 3, 2023, with a negative result. ULP-D's record lacked TB history and	0 660		

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0 660	Continued From page 7 symptom screen completed at hire. On April 24, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the licensee completed screening for all new employees. Also, CNS-A stated some employee records had not yet been received and filed with licensee. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) dated April 3, 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's Tuberculosis Screening/Prevention policy dated January 5, 2023, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements. - risk assessment; - TB screening; and - staff education 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	0 680		

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0 680	Continued From page 8 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not 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 staff, visitors, and residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 9 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - development of communication plan; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - emergency prep training and testing; - emergency prep training program; and - emergency prep testing requirements; On April 22, 2024, at 12:02 p.m., licensed assisted living director (LALD)-B stated the licensee was not aware of the required EPP content. The licensee's Emergency Preparedness policy dated January 5, 2023, indicated [licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 10	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. The licensee also failed to provide a smoke alarm in the residents sleeping room. This deficient condition had the ability to affect all staff and residents.	0 780		

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	36107	A. BUILDING: _____ B. WING _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VIE LIVING LLC	7001 EMERSON AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 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: On a facility tour on April 23, 2024, at 10:46 a.m. with licensed assisted living director (LALD)-B, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD-B tested the smoke alarms outside the bedrooms and could not be heard throughout the facility. It was also observed that resident room S smoke alarm was not working. LALD-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 820 SS=I	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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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 provide properly sized egress window for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 April 23, 2024, at 10:45 a.m., survey staff conducted a facility tour with licensed assisted living director (LALD)-B. During facility tour, survey staff observed the following: Survey staff measured and verified egress window measurement of the openable area to be 40.25" high x 17.5" wide for a total of 704 square inches in occupied resident room E. Survey staff measured and verified egress	0 820		

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0 820	Continued From page 13 window measurement of the openable area to be 40.25" high x 17.5" wide for a total of 704 square inches in occupied resident room S. Survey staff measured and verified egress window measurement of the openable area to be 17" high x 32.5" wide for a total of 552.5 square inches in occupied resident room H. Survey staff measured and verified egress window measurement of the openable area to be 12" high x 32.5" wide for a total of 390 square inches in occupied resident room M. Survey staff measured and verified egress window measurement of the openable area to be 16.5" high x 32.5" wide for a total of 536.25 square inches in occupied resident room O. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". TIME PERIOD FOR CORRECTION: Immediate The immediacy was not lifted at the time of exit on April 24, 2024.	0 820		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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01500	Continued From page 14 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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01500	Continued From page 15 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 annual training completed included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on August 28, 2022, to perform direct care services to the licensee's residents. ULP-D's My Transcript dated February 14, 2024, indicated ULP-D had completed the following annual training: - assisted living Bill of Rights for 0.75 credits; - emergency preparedness human hazards for 0.75 credits; - emergency preparedness overview for 0.75 credits; and - emergency preparedness site and natural	01500		

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01500	Continued From page 16 hazards for 0.75 credits for a total of 3.25 credits ULP-D's record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; - Infection control techniques; - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery. On April 24, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the information above was all the annual training ULP-D had received for the year. Also, licensed assisted living director (LALD)-B stated licensee provided and assigned all employees with required annual training at the same time of the year regardless of when they started working for licensee. The licensee Assisted Living Annual Training policy dated January 5, 2023, indicated; 1. All assisted living employees will complete annual education on the following topics: a. Reporting of maltreatment of vulnerable adults under section 626.557 b. Assisted living bill or rights c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights d. Infection control techniques used in the home and implementation of infection control standards	01500		

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01500	Continued From page 17 including: i. Hand washing ii. Need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases e. Effective approaches for problem solving when working with challenging behaviors f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders g. Review of policies and procedures relating to the provision of assisted living services and how to implement them h. Principles of person-centered planning and service delivery i. How person-centered planning and service delivery applies to direct support services provided by staff j. Emergency and disaster training 2. Annual training will be documented in accordance with the documentation policy. 3. Direct-care staff will complete 8 hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	01530		

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01530	Continued From page 18 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-C, 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 a widespread scope (when problems are pervasive	01530		

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01530	Continued From page 19 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C ULP-C started employment with the licensee on August 24, 2023. ULP-C's My Transcript dated between August 31, 2023, and September 4, 2023, indicated ULP-C had completed dementia training in the following topics: - dementia activities for 0.5 credit; - dementia communication overview for 1 credit; - dementia communication reality and validation for 0.75 credits; - dementia overview for 1 credit; - dementia person centered care for 0.75 credit; - dementia problem solving, anger and aggression for 0.5 credit; and - dementia problem solving mood swings and personality changes for 0.5 credit, for a total of 5 hours out of the required 8 hours of initial dementia training. ULP-D ULP-D started employment with the licensee on April 3, 2023. ULP-D's My transcript dated between January 4, 2024, and April 6, 2024, lacked evidence ULP-D had completed the required 8 hours of initial dementia training in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and	01530		

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01530	Continued From page 20 - person-centered planning and service delivery. On April 24, 2024, at 2:30 p.m., licensed assisted living director (LALD)-B stated they were responsible for staff dementia training and that the licensee assigned each employee the required topics. Also, LALD-B stated they were not aware the topics assigned did not meet the required 8 hours of initial dementia training. Further, LALD-B stated most likely all employees will be short on the required initial dementia training hours. The licensee's Dementia Education policy dated January 5, 2023, indicated direct care employees must have completed at least eight (8) hours of initial education within 160 working hours-of-the employment start date in the following topics: a. an explanation of Alzheimer's disease and other dementias; b. assistance with activities of daily living (ADL's); c. problem solving with challenging behaviors; d. communication skills; and e. person centered planning and service delivery. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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	01620		

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01620	Continued From page 21 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment 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 of the residents). The findings include: R2's diagnoses included major depression and	01620		

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01620	Continued From page 22 type 2 diabetes. R2's Service Plan dated March 23, 2023, indicated R2 received the following services: home health aide services, resident review/reassessment, and medication administration. R2's record included 90 Day Assessments dated June 22, 2023, September 21, 2023, and January 8, 2024. The September assessment was over 90 days by one day, and the January assessment was over 90 days by 20 days. On April 24, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated the licensee's former nurse quit her job and CNS-A was not able to catch up on the assessments and her other responsibilities. Also, CNS-A stated all resident 90-day assessments were late. The licensee's Comprehensive Nursing Assessment policy dated January 5, 2023, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 23 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included 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, 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).	01650		

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01650	Continued From page 24 The findings include: R2 was admitted for assisted living services on March 10, 2023. R2's diagnoses included major depression and type 2 diabetes. R2's Service Plan dated March 23, 2023, indicated R2 received the following services: home health aide services, resident review/reassessment, and medication administration. R2 service plan lacked the following content: - information and a method to contact the facility. On April 24, 2024, at 3:00 p.m., licensed assisted living director (LALD)-B stated the service plan was part of the contract and that the contract had the information and method to contact facility. When the surveyor requested to know why licensee had provided contract and service plan as two separate documents, LALD-B stated when printing they were different documents and residents signed them separately. Also, LALD-B stated all resident service plans will be missing the licensee's contact information. The licensee's Service Plan policy dated January 5, 2023, indicated the service plan includes the following: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36107	A. BUILDING: _____ B. WING _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VIE LIVING LLC	7001 EMERSON AVENUE NORTH BROOKLYN CENTER, MN 55430

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01650	Continued From page 25 d. An identification of staff or categories of staff who will be providing services; e. A schedule and method for the next planned assessment or monitoring; f. A schedule and method for the next planned monitoring of staff providing services; and, g. A contingency plan that includes: - Actions licensee will take if scheduled services cannot be provided; - Information regarding how the resident can contact licensee; - The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and, - How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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	01880		

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	36107	A. BUILDING: _____ B. WING _____	04/24/2024

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01880	Continued From page 26 review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access, and the licensee failed to ensure prescription medications were stored according to the manufacturer's directions 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 of the residents). The findings include: MEDICATION STORAGE On April 23, 2024, at 9:06 a.m., the surveyor observed an unlocked medication refrigerator on the main level of the split entry home behind the nursing desk in the living area with the following medications: one unopened box of insulin pens and another open box with 3 insulin pens. MANUFACTURING DIRECTIONS On April 23, 2024, at 9:06 a.m., the surveyor observed an unlocked medication refrigerator with insulin pens. The thermometer in the refrigerator indicated the internal temperature was 35 degrees Celsius. The licensee lacked a daily temperature log to monitor the internal temperature. On April 23, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee was not aware of the medication refrigerator temperature monitoring requirement. Also, CNS-A stated the refrigerator lock was not working and needed to	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36107	A. BUILDING: _____ B. WING _____	04/24/2024

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01880	Continued From page 27 be fixed. The undated Novolog box/insert instructions for Novolog indicated to store refrigerated at 2 degrees Celsius to 8 degrees Celsius (36 degrees Fahrenheit to 46 degrees Fahrenheit) until first use. The licensee's Storage policy dated January 5, 2023, did not address the storage of refrigerated medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the 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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36107	A. BUILDING: _____ B. WING _____	04/24/2024

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01910	Continued From page 28 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication with all the required content for one of one discharged 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: R1 was discharged from the licensee on January 26, 2024. R1's discharge record indicated the licensee managed R1's medications administration. R1's unsigned and undated Discharge Medication List indicated the following required content: - medication name; - medication dose; - frequency; and - medication quantity. R1's disposition record lacked the following required content: - date of disposition; - to whom the medications were given; and - names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 29 On April 22, 2024, at 3 p.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the required content for medication disposition. The licensee's Disposition and Disposal of Medication policy dated January 5, 2023, indicated the disposal of discontinued medications for residents receiving the medication management program will be completed in a safe manner by appropriate personnel. The policy lacked the content for disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *04/22/24*
Time: 13:45:38
Report: 1021241097

Food and Beverage Establishment Inspection Report

Location:
Bella Vie Living LLC
7001 Emerson Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038386
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE SPRAY BOTTLE OF CLEANER/SANITIZER ON-SITE IS NOT APPROVED TO BE USED WITH FOOD CONTACT SURFACES. STAFF WILL GET APPROVED BLEACH TO BE ABLE TO SANITIZE. FACT SHEET SENT WITH REPORT.

Comply By: 04/26/24

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

FOOD THERMOMETER ON-SITE IS A DIAL THERMOMETER. PROVIDE A DIGITAL THIN PROBE THERMOMETER AS DESCRIBED IN RULE ABOVE.

Comply By: 04/29/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.

Comply By: 04/25/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

VENTILATION FILTERS UNDER THE MICROWAVE AND ABOVE THE STOVE CONTAINS ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/29/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE LAMINATE COUNTERTOPS IN THE KITCHEN DISPLAY A NOTICEABLE WEAR AND TEAR, INCLUDING MISSING SECTIONS WHICH MAKES THEM HARD TO CLEAN AND MAINTAIN. REPAIR OR REPLACE.

Comply By: 10/22/24

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 38 Degrees Fahrenheit - Location: WHIRLPOOL A REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLICED HAM - WHIRLPOOL A REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SHREDDED LETTUCE - WHIRLPOOL A REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 37 Degrees Fahrenheit - Location: WHIRLPOOL B REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH HOUSE MANAGER, GAYLE DIRCKS AND HEALTH REGULATION DIVISION NURSE EVALUATOR, BENARD NYANGENA.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 4 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH HOUSE MANAGER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN SINK IS A ONE COMPARTMENT SINK. STAFF HAVE DESIGNATED THAT SINK

AS A HANDWASHING SINK. ESTABLISHMENT WASH PRODUCE IN A BOWL, SEPARATE FROM THE HANDWASHING SINK. ESTABLISHMENT WILL NEED TO REPLACE THE ONE COMPARTMENT SINK TO A TWO COMPARTMENT SINK TO BE ABLE TO USE THE SINK TO PREPARE FOOD.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, LAMINATE FLOORS AND LAMINATE COUNTERTOPS. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021241097 of 04/22/24.

Certified Food Protection Manager: GAYLE A. DIRCKS

Certification Number: FM112346 Expires: 07/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

GAYLE DIRCKS
HOUSE MANAGER

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us