Electronically Delivered

July 31, 2025

Licensee
Beehive Homes of Duluth
4014 Trinity Road
Duluth, MN 55811

RE: Project Number(s) SL31350016

Dear Licensee:

On June 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 3, 2025. 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,

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

KKM

Electronically Delivered

April 30, 2025

Licensee
Beehive Homes Of Duluth
4014 Trinity Road
Duluth, MN 55811

RE: Project Number(s) SL31350016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2025, 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.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	31350	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

(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 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: SL31350016-0 On March 31, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 38 residents; 38 receiving services under the Assisted Living Facility with Dementia Care license. On April 2, 2025, an immediate correction order was identified for correction order 1290. The licensee took actions to mitigate immediacy, however, the correction order remains at a scope and level of widespread, level three (l).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance 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 to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and contact information for the Minnesota Adult Abuse Reporting Center. This had the potential to affect all current 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:	0 550		

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0 550	Continued From page 2 During the facility tour on March 31, 2025, at 11:18 a.m., the surveyor observed, and confirmed with clinical nurse supervisor (CNS)-B, the licensee's grievance procedure was posted at the main entrance within the facility; however, lacked the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and contact information for the Minnesota Adult Abuse Reporting Center (MAARC). On April 4, 2025, at 11:10 a.m., licensed assisted living director (LALD)-A reviewed the licensee's grievance procedure and stated the contact information for MAARC and Office of Ombudsman for Mental Health and Developmental Disabilities were not included in the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 3 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-F, ULP-R). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated before ULPs were able work with the residents, staff were required to complete Relias training (online training program) and competency skills evaluations.	0 650		

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0 650	Continued From page 4 ULP-F ULP-F was hired October 1, 2019, to provide direct care services to residents of the facility. On April 1, 2025, at 7:47 a.m., the surveyor observed ULP-F administering R4's scheduled morning medications. ULP-F's employee record lacked evidence ULP-F had demonstrated competency to the registered nurse (RN) in medication administration as required. On April 2, 2025, at 12:25 p.m., ULP-F stated ULP-F was trained in medication administration and could not recall what paperwork had been completed at the time of ULP-F's training. ULP-F stated ULP-F's medication training included one on one was with a previous RN who no longer worked for the licensee. On April 2, 2025, at 1:11 p.m., LALD-A stated they were unable to find documentation in ULP-F's employee record competency evaluations including medication administration. LALD-A stated ULP-F was trained a few years ago by an RN who no longer was employed by the licensee. LALD-A stated they were making changes to their training program and would be including skill tests for all delegated tasks in their annual training. On April 3, 2025, at 12:10 p.m., CNS-B stated ULP-F's competency demonstration was completed by another a previous RN who had worked for the licensee. CNS-B stated they would have to review staff records to ensure all staff who administered medications had the required training records and would have to be retrained if necessary.	0 650		

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0 650	Continued From page 5 ULP-R ULP-R was hired August 8, 2022, to provide direct care services to residents of the facility. On April 3, 2025, at 9:21 a.m., the surveyor observed ULP-R assist R4 with dressing, grooming and transferring with the use of a patient lift (mechanical lift using a sling allowing to safety transfer from one service to another). ULP-R's employee record contained an supervised skill observed for the use of Hoyer (mechanical lift) by a RN completed September 1, 2022; however, ULP-R's employee record lacked evidence ULP-R had completed training and a competency evaluations for the following required topics: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids ; and - dressing and assisting with toileting. On April 3, 2025, at 12:00 p.m., LALD-A stated they were unable to find ULP-R's training and competency evaluations. LALD-A stated the RN who previously was employed by the licensee completed ULP-R's training and supervised the Hoyer task and was no longer employed by the licensee. LALD-A stated they would have to audit all employee records to ensure staff have the appropriate documentation indicating staff were trained and deemed competency. The licensee's Administration of Medication by Unlicensed Personnel policy dated March 15, 2022, indicated unlicensed personnel that satisfy the training requirements, have been determined	0 650		

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0 650	Continued From page 6 competent to follow the procedures and have delegated the responsibility by the RN, may administer medications. The licensee's Personnel Records policy dated March 15, 2022, indicted a personnel record for each person would include a record of all required training for unlicensed personnel and competency determinations. Personnel files would be retained for at least three years after an employee ceases to be employed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	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:	0 660		

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0 660	Continued From page 7 Based on observation, interview, and record review, the licensee failed to ensure one of two employees (ULP)-P completed the required training for tuberculosis (TB) upon hire. 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: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for assigning staff training through Relias (online training program) and the licensee staff were trained on TB upon hire and annually. The licensee's Direct Care Staff schedule dated March 30, 2025, to April 5, 2025, indicated ULP-P was scheduled to work 7:00 a.m. to 3:00 p.m., on the following days: -Monday, March 31; -Tuesday, April 1; -Friday, April 4; and -Saturday, April 5. During the survey on March 31, 2025, from 11:00 a.m., through 3:00 p.m., the surveyor observed ULP-P providing direct care services to the residents at the facility. ULP-P was hired on February 27, 2025, to provide direct care services to residents of the	0 660		

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0 660	Continued From page 8 facility. ULP-P'S employee record included a training transcript printed April 1, 2025, indicated ULP-P was assigned a Relias training course titled "Infection Control: Essential Principles" with a completion date by March 29, 2025; however, ULP-P had not completed the infection control module. On April 2, 2025, at 2:08 p.m., LALD-A stated the assigned Relias infection control training included education on TB and stated ULP-P was reminded on March 21 and 31, 2025, to complete assigned Relias training. LALD-A stated ULP-P's training transcript indicated ULP-P had not completed infection control training including TB training. The licensee's Personnel Records policy dated March 15, 2022, indicted a personnel record for each person would include a record of all required training for unlicensed personnel and competency determinations. 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 9 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency disaster plan with all the required content. 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: During the entrance conference on February 11, 2025, at 9:14 a.m., licensed assisted living	0 680		

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0 680	Continued From page 10 director (LALD)-A was identified as responsible for the development and maintaining the licensee's emergency preparedness plan (EPP). During the facility tour on February 11, 2025, at 10:06 a.m., with clinical nurse supervisor (CNS)-B, the licensee's emergency preparedness plan was not observed in the facility in a conspicuous location available to residents and visitors. CNS-B stated the licensee's EPP was located in the front of the facility in the ULPs office work space. The licensee's Emergency Preparedness Plan dated 2022, lacked an EPP with the following requirements: -a annual review of the licensee's EPP -quarterly review of the missing resident policy, last documented review date of March 15, 2022; -development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal; - a medical record documentation system to preserve resident information, security, and availability; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; -a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; - primary and alternative means for	0 680		

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(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
0 680	Continued From page 11 communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information from the EPP with residents and their families; and -emergency prep testing requirements of the licensee's emergency preparedness plan with documentation of the facility's analysis and response. On April 3, 2025, at 1:18 p.m., LALD-A stated LALD-A had not had time to review the licensee's emergency preparedness plan since starting in new position. The surveyor and LALD-A reviewed the licensee's EPP and LALD-A stated she was unable to find policies and procedures in place for the above noted topics. The licensee's Emergency Disaster policy dated 2022, indicated the licensee developed and coordinated plans with state and local emergency disaster authorities to respond to potential emergencies and disasters. The licensee and the administrator would review and update the plan as necessary to confirm with local emergency plans and the plan would be posted in a prominent location throughout the facility. would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with Centers for Medicare and Medicare Services State Operation Manual Appendix Z. The licensee's emergency plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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	31350	A. BUILDING: _____ B. WING _____	04/03/2025

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0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 2, 2025, from 11:15 a.m. to 12:45 p.m., with licensed assisted living director (LALD)-A, and housing manager (HM)-Q, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a delayed egress locking system installed on all exit doors leading to the exterior exit path. During an interview at 10:50 a.m., LALD-A, and	0 775		

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0 775	Continued From page 13 HM-Q, stated the procedures required to operate and unlock the delayed egress door locking system were not included in the fire safety and evacuation plan. It was explained the procedures required to operate and unlock the delayed egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 14 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 a facility tour on April 2, 2025, from 11:15 a.m. to 12:45 p.m., with licensed assisted living director (LALD)-A, and housing manager (HM)-Q, the surveyor made the following observations of facility disrepair: EMERGENCY STAND BY POWER GENERATOR MAINTENANCE During the tour and interview on April 2, 2025, at 10:45 a.m., the surveyor requested documentation of required maintenance of the emergency stand by power generator. The only documentation provided was the annual service provided by an outside vendor. On April 2, 2025, at 10:09 p.m., LALD-A, provided an email indicating the generator automatically runs once a week and the panel in the mechanical in Hive 2 building will indicate any faults in the system. No further information was provided. It was explained that emergency stand by power generators identified as part of the emergency preparedness plan are required to be maintained in accordance with NFPA 110 (Testing and	0 800		

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0 800	Continued From page 15 Service Requirements for Standby Power Systems). During the facility tour LALD-A, verified the above listed observations while accompanying on the tour. During the facility tour LALD-A, also stated documentation was only available for annual service of the generator and no additional documentation was available. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 16 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 2, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A, and housing manager (HM)-Q, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation	0 810		

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0 810	Continued From page 17 indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by providing documentation the required employee training was provided at hire only. Documentation was not provided indicating FSEP training was provided and completed as required by staff twice annually. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required FSEP training was provided to residents at least annually. During an interview on April 2, 2025, at 10:15 a.m., LALD-A, and HM-Q, stated documentation was not available indicating employees received required FSEP training twice annually, and residents were provided FSEP training once annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what	0 930		

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0 930	Continued From page 18 circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A stated the licensee's resident contract was the same contract used for all residents. R3 R3's start of services was January 4, 2024. R3's Service Plan dated March 13, 2025, indicated R3 received services including	0 930		

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0 930	Continued From page 19 assistance with transfers, dressing, grooming, bathing, toileting, medication administration, safety checks, housekeeping and laundry. R4 R4's start of services was December 12, 2021. R4's Service Plan dated January 27, 2025, indicated R4 received services including assistance with bathing, dressing, grooming, ambulation, safety checks, medication administration, toileting, housekeeping and laundry. R3 and R4's Residential Contracts signed December 27, 2023, and December 6, 2021, lacked a written contract with the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur. On April 4, 2025, at 11:10 a.m., LALD-A reviewed the licensee's resident contract and stated the contract lacked the above required content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 20 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for four of ten employees (activities (A)-K, cook-(C)-O, unlicensed personnel (ULP)-F, ULP-G). In addition, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for three of nine employees (licensed assisted director (LALD)-A, ULP-J, C-N). This had the potential to affect all residents living within the facility. 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:	01290		

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01290	Continued From page 21 This resulted in an immediate correction order on April 1, 2025. BACKGROUND STUDY CLEARANCE A-K A-K was hired July 21, 2022, to provide enrichment activities for the residents at the assisted living facility. On March 31, 2025, and April 1, 2025, during the course of the survey, the surveyor observed A-K direct and participate in resident organized group activities. On April 1, 2025, at 9:20 a.m., A-K stated she worked in the activities department and would be working until 7:00 p.m. A-K stated there was usually an activity staff scheduled to work seven days a week. C-O C-O was hired July 6, 2024, to provide dietary services for the residents at the assisted living facility. A-K and C-O's records lacked a cleared background study. COVID-19 EXPIRED BACKGROUND STUDIES ULP-F ULP-F was hired October 1, 2019, and begun to provide direct care services for the residents at the assisted living facility August 1, 2021. On April 1, 2025, at 10:01 a.m., the surveyor observed ULP-F administering R2's scheduled	01290		

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01290	Continued From page 22 morning medications. ULP-F was not under direct supervision. ULP-F's employee record contained a cleared background study notice issued by DHS dated October 1, 2019, under the licensee's comprehensive license. ULP-G ULP-G was hired August 3, 2021, to provide direct care services for the residents at the assisted living facility. ULP-G's employee record contained a cleared background study notice issued by DHS dated August 3, 2021. The licensee's NETStudy 2.0 employee roster printed on March 31, 2025, indicated ULP-F and ULP-G had an expired COVID-19 background studies effective December 31, 2022. BACKGROUND AFFILIATION LALD-A LALD-A was hired on September 7, 2023, to oversee the daily operations of the assisted living facility. LALD-A's record contained a cleared background study notice issued by DHS dated September 20, 2022. The background study was affiliated to a medical center with the HFID 600. ULP-J ULP-J was hired on February 20, 2019, to provide direct care services to the residents at the assisted living facility. ULP-J's record contained a cleared background	01290		

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01290	Continued From page 23 study notice issued by DHS dated February 21, 2019. The background study was affiliated under the previous comprehensive licensee HFID 31339. C-N C-N was hired on April 16, 2024, to provide dietary services to the residents at the assisted living facility. C-N's employee record contained a DHS background study notice dated April 2023. The background study was affiliated to another care center with the HFID 861. LALD-A, ULP-J, and C-N's records lacked documentation of a cleared background study affiliated with the licensee's current HFID 31350. On March 3, 2025, at 2:07 p.m., the surveyor reviewed the DHS NETStudy 2.0 employee roster printed March 31, 2025, and the licensee's active employee list with LALD-A and ULP-E. ULP-E stated she was responsible for submitting employee background studies and was not aware the above noted employees did not have current background studies or had not been affiliated with the licensee's HFID 31350. The licensee's Screening of Home Care Job Applicants policy dated March 15, 2022, indicated all job applicants would be screened to assure compliance with applicable state laws and our facility's requirements including background checks. No new employees would have unsupervised direct contact with residents until all required screenings had been satisfactorily completed and any applicable licenses, regulations or certifications had been verified.	01290		

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01290	Continued From page 24 The licensee's Personnel Records policy dated March 15, 2022, indicated each personnel record would be kept up-to-date and comply with the assisted living law and and other relevant laws. The personnel record for each employee would include documentation of a completed criminal background study as required. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information provided. TIME PERIOD OF CORRECTION: Immediate	01290		

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01370	Continued From page 25	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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	31350	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

(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
01370	Continued From page 26 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two unlicensed personnel, (ULP)-P. 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: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated before new ULPs were able to work on the floor with residents, staff were required complete all of their training through Relias (online training program). The licensee's Direct Care Staff schedule dated March 30, 2025, to April 5, 2025, indicated ULP-P was scheduled to work 7:00 a.m. to 3:00 p.m., on the following days: -Monday, March 31; -Tuesday, April 1; -Friday, April 4; and -Saturday, April 5.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 27 During the course of the survey on March 31, 2025, from 11:00 a.m. through 3:00 p.m., the surveyor observed ULP-P providing direct care services to the residents at the facility. ULP-P was hired on February 27, 2025, to provide direct care services to the residents of the licensee. ULP-P's employee record lacked evidence ULP-P completed the following required trainings: -reports of changes in the client's condition to the supervisor designated by the home care provider; -basic infection control, including blood-borne pathogens; and -maintenance of a clean and safe environment -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; and -understanding appropriate boundaries between staff and clients and the client's family. On April 2, 2025, at 2:08 p.m., LALD-A stated ULP-P had not completed all the required training noted above. LALD-A stated ULP-P was reminded on March 21 and 31, 2025, to complete Relias training. LALD-A stated they planned to have ULP-P complete any missing training on ULP-P's next scheduled day of work. The licensee's Requirements for Instructions, Training Content, And Competency Evaluations For Unlicensed Personnel policy dated August 21, 2024, indicated training and competency evaluations for all unlicensed personnel must include the following: -documentation requirements for all services provided; -reports of changes in the residents's condition to	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 28 the supervisor designated by the facility; -basic infection control, including blood borne-pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -medication, exercise and treatment reminders; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness and confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assisted devices. When the registered nurse or licensed health professional delegates tasks, they must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to completely follow the procedures and perform the tasks. No further information was provided.	01370		

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01370	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of one unlicensed personnel (ULP-P). 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	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 30 a limited number of staff are involved or the situation has occurred only occasionally The findings include: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated before new ULPs were able to work on the floor with residents, staff were required to complete all of their training through Relias (online training program). The licensee's Direct Care Staff schedule dated March 30, 2025, to April 5, 2025, indicated ULP-P was scheduled to work 7:00 a.m. to 3:00 p.m., on the following days: -Monday, March 31; -Tuesday, April 1; -Friday, April 4; and -Saturday, April 5. During the course of the survey on March 31, 2025, from 11:00 a.m., through 3:00 p.m., the surveyor observed ULP-P providing direct care services to the residents at the facility. ULP-P was hired on February 27, 2025, to provide direct care services to the residents of the licensee. ULP-P's employee record lacked evidence ULP-P completed the following required trainings: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 31 developmental needs of the resident. On April 2, 2025, at 2:08 p.m., LALD-A stated ULP-P had not completed all the required Relias training noted above. LALD-A stated ULP-P was reminded on March 21 and 31, 2025, to complete Relias training. LALD-A stated they planned to have ULP-P complete any missing training on ULP-P's next scheduled day of work. The licensee's Requirements for Instructions, Training Content, And Competency Evaluations For Unlicensed Personnel policy dated August 21, 2024, indicated training and competency evaluations for all unlicensed personnel must include the following: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation, - range of motion and positioning; and - administering medications or treatments as required. When the registered nurse or licensed health professional delegates tasks, they must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to completely follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01380		

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01380	Continued From page 32 (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (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 staff member 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	01470		

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01470	Continued From page 33 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 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 observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (unlicensed personnel (ULP)-P). 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	01470		

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BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

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01470	Continued From page 34 situation has occurred only occasionally). The findings include: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated before new ULPs were able to work on the floor with residents, staff were required complete their training through Relias (online training program) and competency evaluations with the RN. The licensee's Direct Care Staff schedule dated March 30, 2025, to April 5, 2025, indicated ULP-P was scheduled to work 7:00 a.m., to 3:00 p.m., on the following days: -Monday, March 31; -Tuesday, April 1; -Friday, April 4; and -Saturday, April 5. During the survey on March 31, 2025, from 11:00 a.m. through 3:00 p.m., the surveyor observed ULP-P providing direct care services to the residents at the facility. ULP-P was hired on February 27, 2025, to provide direct care services to residents of the facility. ULP-P's employee record lacked documented evidence of the following required orientation: - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On April 2, 2025, at 2:08 p.m., LALD-A stated ULP-P had not completed all the required training	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 35 noted above. LALD-A stated ULP-P was reminded on March 21, and 31, 2025, to complete assigned Relias training. LALD-A stated they planned to have ULP-P complete any missing training on ULP-P's next scheduled day of work. The licensee's Assisted living Orientation policy dated March 15, 2022, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services. At a minimum the orientation must include the following topics: -an overview of Minnesota's Assisted Living law; -an introduction and review of the facility's policies and procedures related to the provisions of assisted living services by the individual staff person; -handling of emergencies and use of services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct services provided by the staff person; -handing of residents' complaints, reporting of complaints, where to report, including information to the Office of Health Facility Complaints; -consumer advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia training as required for one of two employees (unlicensed personnel (ULP)-P). This had the potential to affect all 38 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01560		

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01560	Continued From page 37 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 31, 2025, at 9:49 a.m., licensed assisted living director (LALD)-A she was responsible for assigning employee training. Clinical nurse supervisor (CNS)-B stated before staff were able work with the residents, staff were required to complete dementia training through Relias (online learning program). The licensee's Direct Care Staff schedule dated March 30, 2025, to April 5, 2025, indicated ULP-P was scheduled to work 7:00 a.m. to 3:00 p.m., on the following days: -Monday, March 31; -Tuesday, April 1; -Friday, April 4; and -Saturday, April 5. During the course of the survey on March 31, 2025, from 11:00 a.m. through 3:00 p.m., the surveyor observed ULP-P provide direct care services to the residents at the facility. ULP-P was hired on February 27, 2025, to provide direct care services to residents of the facility. ULP-E's employee record did not include training for: - assistance with activities of daily living related to dementia; - communication skills related to dementia; and - person-centered planning and service delivery. On April 2, 2025, at 2:08 p.m., LALD-A stated	01560		

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01560	Continued From page 38 ULP-P had not completed all the required dementia training noted above and planned to have ULP-P complete any missing training on ULP-P's next scheduled day of work. 144G.64 TRAINING IN DEMENTIA CARE REQUIRED. (a) All assisted living facilities must meet the 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; (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working	01560		

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BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

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01560	Continued From page 39 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; (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 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; and (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. The licensee's Annual Training Requirement	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31350	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01560	Continued From page 40 policy undated, indicated all staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	02040		

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	31350	A. BUILDING: _____ B. WING _____	04/03/2025

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02040	Continued From page 41 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 of available documentation and interview were conducted April 2, 2025, at 10:55 a.m., with licensed assisted living director (LALD)-A, and housing manager (HM)-Q, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property and building. A hazard vulnerability assessment or safety risk must be performed on and around the property in assisted living with dementia care facilities. The hazards indicated on the assessment must be assessed and mitigated to protect residents from harm. During an interview on April 2, 2025, at 10:55 a.m., LALD-A, and HM-Q, stated an HVA had not been performed and documented on and around the property and building. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

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02140	Continued From page 42 (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care (ALFDC) license effective November 1, 2024. During the entrance conference on March 31, 2025, at 9:49 a.m., licensed living director (LALD)-A named clinical nurse supervisor (CNS)-B as the responsible staff overseeing/providing staff training for dementia care.	02140		

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02140	Continued From page 43 During the survey from March 31, 2025 through April 3, 2025, the suveyor observed CNS-B provide care and services to the residents of the assisted living and oversee the supervision of care and services. On April 2, 2025, at 3:29 p.m., LALD-A stated they thought CNS-B had completed an approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care; however, were unable to find any supporting documentation. On April 3, 2024, at 12:10 p.m., CNS-B stated she had completed several dementia training courses through Relias (online training program) and was not aware the dementia trainings completeed were not approved dementia trainings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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	31350	A. BUILDING: _____ B. WING _____	04/03/2025

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02320	Continued From page 44 Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-F). 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: During the entrance conference on March 31, 2025, at 9:49 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents. R3's diagnoses included chronic obstructive pulmonary disease (COPD), cognitive communication disorder, and right ankle fracture. R3's Service Plan dated March 11, 2025, indicated R3 received medication administration four times a day. ULP-F's employee record included a 2024 Annual Staff Training check-off list dated February 20, 2024 indicating ULP-F reviewed the licensee's policy and procedure on medication administration. On March 31, 2025, at 11:11 a.m., the surveyor observed medication cart one with CNS-B and registered nurse (RN)-C. In the top drawer of the	02320		

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02320	Continued From page 45 medication cart was a clear plastic medication cup with multiple medications in the cup. The plastic medication cup had the number 16 written on the outside of the cup with a black marker, no other information was on the cup of medications. Also, observed in medication cart one was a small white envelope with the time 8:00 a.m., written on the outside of the envelope and in the envelope were two individual medications. Immediately following the observation, CNS-B stated staff should not be setting up medications prior to administering and leaving them in the medication cart. CNS-B stated if staff attempted to administer medications and a resident declined, staff should document in the resident record the resident declined, put the medications in an envelope, label the envelope with the resident name, date and bring to the nurse for destruction. On March 31, 2024, at 11:12 a.m., ULP-F approached medication cart one and stated the pills in the cup were for R3 and ULP-F prepared R3's medications to administer that morning; however, R3 was still in bed so ULP- F put R3's pills in the top drawer to administer once R3 was up. ULP-F stated the pills in the white envelope were supposed to be put in the medication storage room to be destroyed. ULP-F stated ULP-F's normal process for medication administration was to prepare the resident's medications then immediately administer the medication. ULP-F stated next time they would make sure R3 was up out of bed before preparing R3's medications. The licensee's Administration of Medication by Unlicensed Personnel policy dated March 15, 2022, indicated unlicensed personnel that satisfy the training requirements, have been determined	02320		

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02320	Continued From page 46 competent to follow the procedures and have delegated the responsibility by the RN, may administer medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *04/01/25*
Time: 11:00:00
Report: 1016251061

Food and Beverage Establishment Inspection Report

Location:

Beehive Homes Of Duluth
4014 Trinity Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038183
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187224014
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.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP. SINK
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = 167 at Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: COLE SLAW
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: RASPBERRIES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 201 Degrees Fahrenheit - Location: POTATOES
Violation Issued: No

Type: Full
Date: *04/01/25*
Time: 11:00:00
Report: 1016251061
Beehive Homes Of Duluth

Food and Beverage Establishment Inspection Report

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

COMMENTS:

DISCUSSED ADDITIONAL REQUIREMENTS WEN SERVING A SUSCEPTIBLE POPULATION.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 1016251061 of 04/01/25.

Certified Food Protection Manager: KATIE A. ANDERSON

Certification Number: FM125234 Expires: 05/06/27

Signed: _____
KATIE A. ANDERSON
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us