Electronically Delivered

August 26, 2022

Administrator
BeeHive Homes of Moorhead
1001 Caddy Avenue
Moorhead, MN 56560

RE: Project Number(s) SL34745015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 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#34745015 On, August 1, 2022, through August 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents, all of whom were receiving services under the provider's Assisted Living with dementia license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level 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 August 1, 2022, at 11:43 a.m., LALD-A identified himself as the LALD for the facility. LALD-A obtained an assisted living director license on July 30, 2021. On August 1, 2022, at 12:25 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee.	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 110	Continued From page 2 On August 1, 2022, at approximately 12:30 p.m., immediately after BELTSS website was reviewed with LALD-A. LALD-A confirmed he was not listed as the Director of Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 250	Continued From page 3 (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 250	Continued From page 4 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: During the entrance conference on August 1, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 250	Continued From page 5 chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 250	Continued From page 6 - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 20, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 250	Continued From page 7 - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On August 3, 2022, at 2:30 p.m., LALD-A and RN-C confirmed the licensee conducted orientation, training, and competency evaluations of staff, and a process for evaluating staff performances, provided medication and treatment management services, followed infection control practices, and supervised ULP performing delegated tasks but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0430, 0470, 0480, 0485, 0510, 0580, 0640, 0650, 0680, 0810, 0950, 0970, 1370, 1440, 1460, 1480, 1500, 1540, 1620, 1640, 1650, 1700, 1730, 1760, 1770, 1790, 1830, 1880, 1890, 1910, 1940, 1950, 2110, 2310, and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 430	Continued From page 8 (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R2, R3) with records reviewed. 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 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: Review of R2 and R3's records lacked evidence a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 430	Continued From page 9	0 430		

licenses available and the category of license held by the facility; and
- a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide.

R2
R2's diagnoses included, back pain, bipolar disorder, and mild cognitive impairment.

R2's service plan dated April 8, 2022, indicated R2 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, grooming, dietary, mobility, fall interventions, oral care, communication assist, emergency evacuation, activities and vital sign monitoring.

R3
R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation].

R3's service plan dated July 26, 2022, indicated R3 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, and bathing, dressing, hygiene assistance, oral care, mobility, transferring, fall interventions, communication assist, emergency evacuation, activities and vital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 430	Continued From page 10 sign monitoring On August 2, 2022, at 3:14 p.m., registered nurse (RN)-C confirmed R2 and R3 had not received a written checklist listing all services permitted and provided under the facility's license. Additionally, RN-C stated if "newer" resident files were reviewed, the surveyor would have seen the forms. The licensee's Uniform Assessment Tool policy dated August 1, 2021, indicated the licensee would use a uniform assessment tool that addressed all of the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 470	Continued From page 11 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 staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 16 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license. The facility was licensed for a capacity of 16 residents and had a current census of 16 residents. During the entrance conference on August 1, 2022, at approximately 12:00 p.m., registered nurse (RN)-C stated the usual staffing schedule	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 470	Continued From page 12 for the facility was as follows: - RN-C was on call 24/7 and was onsite Monday through Sunday "every day". RN-C added, Monday through Friday, was her work schedule "if staffed well". RN-C stated her normal hours were from 6:00 a.m., or 7:00 a.m., until 2:00 p.m., or 3:00 p.m. RN-C worked one weekend a month also, with ULPs. - the licensed practical nurse (LPN) worked from 6:00 a.m., or 7:00 a.m., until 2:00 p.m., or 3:00 p.m., and one weekend a month, on the floor. - the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m., to 2:30 p.m., or 8:30 p.m., and 2 additional ULPs at approximately 10:00 a.m. - the afternoon shift "varied". Licensed assisted living director (LALD)-A added they had a mix of 8 hour, 10 hour, and 12 hour shifts. The shift starting and ending times varied depending on the shift hours, which were sometimes 8, 10, or 12 hour shifts. RN-C added they used contracted staff as needed to have the staff coverage needed. - the night shift hours varied also depending on the hours worked, LALD-A and RN-C stated the night shift was staffed with two ULPs. On August 2, 2022, at approximately 3:25 p.m., RN-C stated she had not developed a staffing plan for the facility. The licensee's Staffing & Scheduling policy August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24 hours a day, seven-days a week. No further information was provided.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 470	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 480	Continued From page 14 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 2, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by:	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 485	Continued From page 15 Based on observation, interview and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all 16 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on August 1, 2022, at approximately 12:05 p.m., with registered nurse (RN)-C, the surveyor observed the menu for the day was posted, however, the weekly menu was not posted or made available to residents. On August 1, 2022, at 12:21 p.m., RN-C stated they [the facility] pay for menus and the menus were kept in a book located in the kitchen. RN-C confirmed weekly menus were not provided for the residents. The licensee's Food Service & Menu Planning policy revised August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 510	Continued From page 16	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP-B, ULP-D) and one of one licensed practical nurse (LPN)-F during personal cares for R3, R8. In addition, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding screening of staff. This had the potential to affect all 16 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).	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 510	Continued From page 17 The findings include: HAND HYGIENE ULP-B ULP-B failed to ensure infection control standards were followed during morning cares. On August 2, 2022, at 6:46 a.m., the surveyor observed ULP-B wearing gloves assist R3 who was sitting on the toilet. ULP-B removed the gloves he was wearing and applied a new pair of gloves. ULP-B removed R3's pants and then held the trash can up to R3 to spit in. ULP-B removed R3's brief which had been resting on top of R3's pants. ULP-B removed the gloves he was wearing and applied new gloves. ULP-B applied lotion to R3's legs, and then adjusted the nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) which R3 wore. ULP-B removed gloves and applied new gloves. ULP-B removed R3's slippers, applied support stockings (TEDs), underwear and pants to R3's lower body. ULP-B removed gloves and applied new gloves. ULP-B applied deodorant and lotion to R3's arms. ULP-B wiped R3's nose for him and then handed the tissue to R3. ULP-B removed gloves and applied new gloves. ULP-B applied tooth paste to a toothbrush and brushed R3's teeth and asked R3 to spit in trash can. ULP-B did not complete hand hygiene at any point during the surveyor's observations. On August 2, 2022, directly following the above observation, ULP-B stated, "I wash hands in-between people. should I be doing it more?"	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 510	Continued From page 18 LPN-F, ULP-D LPN-F and ULP-D failed to ensure infection control standards were followed when providing incontinence care. On August 2, 2022, at 7:14 a.m., surveyor observed LPN-F and ULP-D wearing gloves assisting R8 who was lying in bed. LPN-F and ULP-D moved R8's bed out from the wall, pulled back the blanket which covered R8's body and removed the pillow which was positioned between R8's knees. Both staff removed the pants R8 was wearing, and ULP-D got a trash bag and placed R8's pants into it. LPN-F removed the gloves she was wearing and applied new gloves. R8's soiled brief was removed by both staff and put into a trash container by ULP-D. Peri cleaner was applied to R8's perineum [area between the anus and the scrotum.] and LPN-F used several wipes to clean the area, tossing used wipes in the trash container. LPN-F removed gloves and applied new gloves. LPN-F tucked a new brief under R8's bottom and applied moisture protection cream to R8's perineum. LPN-F removed the gloves and applied new gloves. R8 was repositioned by staff. ULP-D applied additional cream to R8's perineum. ULP-D removed the gloves worn and applied new gloves. LPN-F went to the sink and put water on a gauze dressing. ULP-D and LPN-F did not complete hand hygiene at any point during the surveyor's observations. On August 2, 2022, immediately following the above observation, LPN-F stated, "I am just a little nervous, I usually use hand sanitizer." LPN-F removed gloves and washed her hands and put on new gloves. LPN-F removed a gauze dressing from R8's suprapubic catheter site (a hollow	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 510	Continued From page 19 flexible tube that is used to drain urine from the bladder) and applied new dressing. On August 2, 2022, at 7:34 a.m., registered nurse (RN)-C agreed handwashing should be done after cares: TEDs and oral. In addition, RN-C verified hand washing should be done after peri care and before a suprapubic catheter site dressing change The licensee's Infection Control/ Gloves policy dated August 1, 2021, indicated hands are to be washed prior to applying gloves to both hands and hands are to be rewashed after the gloves have been disposed of in a proper receptacle. COVID-19 SCREENING The Minnesota Department of Health (MDH) document titled COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Type Settings, dated June 17, 2022, indicated visitors who have a positive viral test for COVID-19 or symptoms of COVID-19, or who currently meet standards for quarantine should not enter the facility until they meet standards to end quarantine, isolation, or do not have symptoms. Facilities should screen all who enter for criteria that would exclude someone from visiting. On August 2, at 8:06 a.m., the surveyor observed the cook (C)-E preparing a meal for the facility residents in the kitchen. C-E indicated she had not completed covid screening prior to her shift; slowly shook her head and replied, "I am really bad at it. I got here a little late." On August 2, 2022, at 11:50 a.m., RN-C confirmed C-E had not self-screened for COVID	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 510	Continued From page 20 19 as required. RN-C added, "I don't see her [C-E] name there, at least for the last week. I trust them to do it." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 16 residents receiving assisted living services. 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	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 580	Continued From page 21 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 August 1, 2022, at 12:05 p.m., during the entrance conference with the licensed assisted living director (LALD)-A and registered nurse (RN)-C a request was made to review documentation of the licensee's quality management activities. On August 1, 2022, at 12:10 p.m., LALD-A and RN-C confirmed the licensee had not developed an ongoing quality management activity relevant to the size and services provided by the assisted living. RN-C stated, "No, we have not done that yet." The licensee's Quality Management Project policy revised August 1, 2021, verified the licensee would always have at least one documented quality improvement project in place, and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 640	Continued From page 22 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 16 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 August 1, 2022, at approximately 12:20 p.m., during the facility tour, the surveyor did not obverse 911 posted on or near telephones in the commons area as required. On August 1, 2022, at 12:54 p.m., licensed assisted living director (LALD)-A verified the 911 emergency number was not posted at or near telephones or in the commons area.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 640	Continued From page 23 The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 1, 2021, noted the facility would post 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 650	Continued From page 24 least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel (ULP)-B, ULP-D, registered nurse (RN)-C) with records reviewed. 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 August 1, 2022, at 12:02 p.m., RN-C stated she "may be" aware of the required content in the employee records. ULP-B ULP-B was hired on October 9, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-B's employee record lacked the following required content: Training topics: - documentation requirements for all service	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 650	Continued From page 25 provided; - maintenance of a clean and safe environment; - evidence of demonstrated competency of hair and bathing; (ULP-B's filed included a form for hair care and bathing training, dated January 4, 2022, signed by ULP-B but not singed by RN). - evidence of demonstrated competency of teeth/gums cares, and oral prosthetic devices; (ULP-B's file included a form for oral care training, dated January 23, 2022, signed by ULP-B but not signed by RN). - evidence of demonstrated competency of dressing and assisting with toileting; (ULP-B's file included a form for dressing, and toileting training, dated January 4, 2022 signed by ULP-B but not signed by RN). - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - evidence of demonstrated competency standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - communication skills that included preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; - observation, reporting, and documenting of client status; - awareness of commonly used health technology equipment and assistive devices; (ULP-B's file included a form for assistive devices with ULP-B's name on form but no date was on form, and form was not signed by RN). - basic knowledge of body functioning and changes in body functions, injuries, or other observed changes that must be reported to appropriate personnel:, - recognizing physical, emotion, cognitive, and developmental needs of the client; - hand washing; (employee file included a form	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 650	Continued From page 26 for handwashing, dated January 23, 2023, which was signed by RN but "I attest that the employee listed below has successful completed the training evaluation" had not been marked. In addition, the form lacked to include pass or fail for any of the six steps for hand washing, or the three steps of using alcohol-based hand sanitizer.) - evidence of demonstrated competency, safe transfer techniques and ambulation; - evidence of demonstrated competency, range of motioning and positioning: - evidence of demonstrated competency, mechanical lift, - consumer advocacy services; and - review of types of Assisted Living service the employee would provide and provider's scope of license. On August 2, 2022, at approximately 1:00 p.m., the surveyor interviewed ULP-D regarding training. ULP-D confirmed ULP-B and ULP-D went through training together. On August 3, 2022, at 10:17 a.m., the surveyor interviewed ULP-B regarding training. ULP-B verified he had training. On August 3, 2022, at 11:12 a.m., RN-C confirmed she was not sure where all the training forms were, but stated training had been provided. ULP-D ULP-D was hired on October 9, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-D's employee record lacked the following required content:	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 650	Continued From page 27 - evidence of current registration on the Minnesota Department of Health (MDH) nursing assistant registry (NAR). On August 3, 2022, at approximately 11:30 a.m., RN-C was able to produce a current NAR registration for ULP-D. RN-C RN-C was hired on May 17, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-C's employee record lacked the following required content: - job description that included identification of staff persons providing supervision. On August 3, 2022, at approximately 2:15 p.m., RN-C stated the employee who did some of the training was on vacation and she would not answer her phone, adding RN-C was not aware of where the records were put confirming ULP-B's record lacked the above-mentioned training. In addition, RN-C confirmed she had not marked all of the boxes and dated all of the forms correctly. RN-C verified ULP-D's file contained an expired NAR certificate and RN-C's job description did not include by whom RN-C would be supervised. The licensee's Employee Records policy revised August 1, 2021, indicated employee records would include evidence of current professional licensure, registration or certification if required, records of all training and in-service education required and /or provided including record of competency testing as required, current job	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 650	Continued From page 28 description with included identification of supervisors, if any, and verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 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 tenant 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.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 29 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. In addition, the EPP had not been reviewed annually. This had the potential to affect all 16 residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 1, 2022, at approximately 12:10 p.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's EPP lacked the following: - a completed risk assessment; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - a missing resident plan that was reviewed quarterly; - a description of the population served by the licensee; - procedure for sheltering in place; and -tracking system for residents and staff.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 30 On August 1, 2022, at approximately 1:15 p.m., registered nurse (RN)-C confirmed a risk assessment had not been completed. RN-C added the risk assessment sounded familiar; however, she was unable to locate it. Licensed assisted living director (LALD)-A and RN-C verbalized systems in place, however, they did not have a written plan for the facilities approach to meeting the health/safety/security needs of the staff and residents. RN-C confirmed the missing resident plan was not reviewed quarterly and there was not a description of the population served by the licensee. LALD-A and RN-C verified they did not have a procedure for sheltering in place. Regarding the tracking system for residents and staff, RN-C stated the activity person was in charge of that. When asked who would track residents and staff if the activity person was not available, RN-C replied, "that is a good question." In addition, RN-C confirmed the EPP had not been reviewed annually. The licensee's Physical Environment, Fire Protection & Staffing policy revised August 1, 2021, indicated a hazard vulnerability assessment was on file for the facility that identified hazards and assessed with reasonable mitigation strategies employed to protect residents from harm. The licensee's Disaster Planning and Emergency Preparedness policy revised August 1, 2021, stated the facility would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with Centers for Medicare & Medicaid Services (CMS) Appendix Z. No further information was provided.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 31 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 810	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, 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 the potential to affect a large portion or all residents). The findings include: On August 1, 2022, from approximately 2:00 p.m. to 3:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following. 1. Documentation of required employee evacuation drills did not show drills performed every other month. 2. The schedule and required records on training of employees on fire safety and evacuation. 3. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, and relocation.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 810	Continued From page 33 On August 1, 2022, at approximately 3:30 p.m., LALD-A was not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 950	Continued From page 34 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to offer two of two residents (R2, R3) the opportunity to identify a designated representative with records reviewed. 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: R2 R2's diagnoses included, back pain, bipolar disorder, and mild cognitive impairment. R2's service plan dated April 8, 2022, indicated R2 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, grooming, dietary, mobility, fall interventions, oral care, communication assist, emergency evacuation, activities and vital sign monitoring. R2's record included a form for the resident to name an individual of their choice as "Designated Representative" or to decline to name a Designated Representative. The form was left	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 950	Continued From page 35 blank. R3 R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation]. R3's service plan dated July 26, 2022, indicated R3 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, and bathing, dressing, hygiene assistance, oral care, mobility, transferring, fall interventions, communication assist, emergency evacuation, activities and vital sign monitoring. R3's record included a form for the resident to name an individual of their choice as "Designated Representative" or to decline to name a Designated Representative. The form was left blank. On August 2, 2022, at 3:12 p.m., registered nurse (RN)-C verified R2's was not given the opportunity to identify a designated representative, "I didn't think he could do it [name a designated representative]. "I thought he (R2) had to do it [designate a representative]." On August 3, 2022, at approximately 8:45 a.m., RN-C confirmed R3 had not been given the opportunity to identify a designated representative, the form in R3's file was left blank.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 950	Continued From page 36 The licensee's Designated Representative policy revised August 1, 2021, indicated before or at the time of execution of an assisted living contract the facility would offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the resident's choice in designated representative. The form would be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living with dementia care contract did not include language waiving the facility's liability for health, safety, or personal property of a resident (R2, R3). This had the potential to affect all 16 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
0 970	Continued From page 37 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 1, 2022, at approximately 12:05 p.m., a copy of the facility's admission package was requested to include the assisted living contract. On page 15 of the assisted living contract, clause 4, a statement was included that indicated "the resident would hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises". On August 1, 2022, at approximately 3:30 p.m., registered nurse (RN)-C confirmed the same contract was used for all the residents at the assisted living facility. RN-C stated she was surprised the contract was not correct because a lawyer was involved. RN-C later commented an email had been received from the lawyer regarding the contract clause. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 38 (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 (15) awareness of commonly used health technology equipment and assistive devices.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 39 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) for one of one employee (ULP-B) with records reviewed. 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: ULP-B was hired on October 9, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-B had not been trained by a RN in the following areas: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - hair care and bathing; - dressing and assisting with toileting; - training on the prevention of falls; - 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 of confidentiality and privacy; - understanding appropriate boundaries between	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 40 staff and residents and the resident's family; and - procedures to use in handling various emergency situations. On August 3, 2022, at approximately 2:15 p.m., the surveyor reviewed a list of ULP training and competencies with RN-C. RN-C confirmed the above-mentioned topics were taught by a staff "activity person" who was not a RN. In addition, RN-C stated ULP-B and some other staff had been trained the same way, by the same person. The licensee's Competency Training Evaluations policy revised August 1, 2021, indicated prior to the delegation of services they [registered nurse or licensed health professional staff] must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Listed training and competently evaluation included: - hair care and bathing; - dressing and assisting with toileting; - documentation requirements for all services provided; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - training on the prevention of falls; - 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 of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; and - procedures to use in handling various emergency situations.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01440	Continued From page 42 the licensee for two of two unlicensed personnel (ULP)-B and 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 the residents). The findings include: ULP-B ULP-B was hired on October 9, 2021, to provide direct care services to residents at the assisted living facility. On August 2, 2022, at approximately 6:46 a.m., the surveyor observed ULP-B remove R3's slippers, apply support stockings (TEDs), underwear and pants to R3's lower body. ULP-B's 30-Day Performance Report Form was dated November 8, 2021. The report included: customer focus, communication, teamwork & attitude, productivity, safety and dependability. The report did not include supervision of staff performing a delegated task. In addition, a registered nurse (RN) did not complete the form. ULP-D ULP-D was hired on October 9, 2021, to provide direct care services to residents at the assisted living facility. On August 2, 2022, at 7:09 a.m., the surveyor observed ULP-D administer 2 milligrams (ml) of morphine (moderate to severe pain) to R1.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01440	Continued From page 43 ULP-D's 30-Day Performance Report Form was dated November 9, 2021. The report included: customer focus, communication, teamwork & attitude, productivity, safety and dependability. The report did not include supervision of staff performing a delegated task. In addition, a RN did not complete the form. On August 2, 2022, at 11:30 a.m., RN-C verified 30-day supervision of delegated tasks had not been completed for ULP-B or ULP-D. RN-C stated she had worked with them a day and asked if bathing counted. The licensee's Supervision of Staff-Delegated Services policy revised August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for facility and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information as provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01460	Continued From page 44 staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided for one of one employee (registered nurse (RN)-C). In addition, the licensee failed to provide complete staff orientation to assisted living licensing requirements and regulations for one of one employee (unlicensed personnel (ULP)-B) with records reviewed. This had the potential to affect all 16 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was hired on May 17, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-C's employee records lacked documentation assisted living orientation training requirements were completed. On August 2, 2022, at approximately 11:10 a.m.,	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01460	Continued From page 45 RN-C verified RN-C's record did not contain documentation assisted living orientation 144G requirements were completed. ULP-B ULP-B was hired on October 9, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-B's employee record lacked documentation all assisted living orientation training requirements were completed as required: - consumer advocacy services; and - review of types of Assisted Living services the employee would provide and provider's scope of license. On August 2, 2022, at 11:12 a.m., RN-C confirmed ULP-B's employee record did not provide documentation to indicate the assisted living facility training requirements were completed. The licensee's Orientation of Staff and Supervisors & Content policy revised August 1, 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 to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be	01480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01480	Continued From page 46 oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) was oriented specifically to each individual resident and the services to be provided with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on October 9, 2021, to provide direct care services to residents at the assisted living with dementia care facility. ULP-B's employee record lacked documentation of ULP-B's orientation to each individual resident and the resident's needs prior to ULP-B providing services to residents at the facility. On August 2, 2022, at approximately 11:40 a.m., the surveyor requested ULP-B's orientation to the licensee's residents. On August 2, 2022, at approximately 11:45 am., registered nurse (RN)-C provided the Resident	01480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01480	Continued From page 47 Information Binder and stated ULP-B's signature was not on the paper to indicate ULP-B had been orientated to each resident as required. The licensee's Orientation to Resident policy, undated, indicated the facility would orient each staff person responsible for providing assisted living services to that resident and to the specific services to be provided. The orientation may be provided in person, orally, in writing or electronically. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01500	Continued From page 48 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 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01500	Continued From page 49 licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one employee\ (registered nurse (RN)-C) with employee records reviewed. 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: RN-C was hired on May 17, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-C's employee training records lacked evidence RN-C had successfully completed annual training as required, in the following areas: - training of reporting of maltreatment of vulnerable adults; - 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 material and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01500	Continued From page 50 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - effective approaches to use a 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; - 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 - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 2, 2022, at approximately 12:12 p.m., RN-C confirmed she did not complete annual training as required. The licensee's Annual Required Staff Training policy revised August 1, 2021, indicated all staff that perform direct care services at the facility would complete at least eight hours of annual training for each 12 months of employment to include: - training on reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights: - 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01500	Continued From page 51 of contaminated material and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use a 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; - 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 - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not 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	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01540	Continued From page 52 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one direct-care employee (registered nurse (RN)-C) completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter as required. 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: RN-C was hired on May 17, 2019, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-C's employee record lacked documentation RN-C had completed two (2) hours of annual dementia training. On August 2, 2022, at approximately 12:15 p.m., the surveyor and RN-C reviewed the training log;	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01540	Continued From page 53 RN-C verified annual dementia training had not been completed. The licensee's Dementia Training policy revised August 1, 2021, indicated all staff would complete two hours of additional training for each 12 months of work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01620	Continued From page 54 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 14 days for one of one resident (R2) and did not exceed 90 days for two of two residents (R2, R3) with records reviewed. 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 August 1, 2022, at approximately 11:55 a.m., RN-C stated she completed assessments at admission, every 14 days, every 90 days or if there was a big change. RN-C added she had been late on one or two, by a day or two. R2 R2 began receiving assisted living services on November 3, 2021. R2's diagnoses included, back pain, bipolar disorder, and mild cognitive impairment. R2's service plan dated April 8, 2022, indicated R2 received services which included behavioral	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01620	Continued From page 55 management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, grooming, dietary, mobility, fall interventions, oral care, communication assist, emergency evacuation, activities and vital sign monitoring. R2's record included an Admission Assessment dated November 3, 2021, and an assessment dated November 19, 2021, two days after the 14-day assessment was due. R2's record included a Nursing 90-day Assessment dated April 1, 2022, and a Nursing 90-day Assessment dated July 6, 2022, six days after the 90-day assessment was due. R3 R3 began receiving assisted living services on October 19, 2019. R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation]. R3's service plan dated July 26, 2022, indicated R3 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, hygiene assistance, oral care, mobility, transferring, fall interventions, communication assist, emergency evacuation, activities and vital sign monitoring.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01620	Continued From page 56 R3's record included a Nursing 90-day Assessment dated April 1, 2022, and a Nursing 90-day Assessment dated July 5, 2022, five days after the 90-day assessment was due. On August 3, 2022, at approximately 8:30 a.m., RN-C verified R2's assessments were not completed prior to or on day 14, or on or before day 90, as required. On August 3, 2022, at approximately 9:00 a.m., RN- C verified R3's assessment had not been completed timely, as required. The licensee's Assessments, Reviews & Monitoring policy revised August 1, 2021, indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01640	Continued From page 57 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two residents (R3) service plans were revised to include provided services. 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: R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged),	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01640	Continued From page 58 chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation]. On August 2, 2022, at 6:46 a.m., the surveyor observed unlicensed personnel (ULP)-B apply compression stockings (TEDs) to R3's lower extremities and adjust R3's nasal cannula (a hollow tube with two prongs that are placed into the nares to supply oxygen). R3's service plan dated July 26, 2022, did not identify R3 received assistance with TEDs or oxygen. On August 3, 2022, at approximately 8:45 a.m., registered nurse (RN)-C verified R3's current service plan lacked information to include oxygen administration. RN-C added she normally includes TEDs under dressing but confirmed TEDs were not mentioned anywhere on R3's service plan. The licensee's Service Plan policy revised August 1, 2021, confirmed the service plan would be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01650	Continued From page 59 (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 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 observation, interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3) with records reviewed. 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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01650	Continued From page 60 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 R2's diagnoses included, back pain, bipolar disorder, and mild cognitive impairment. R2's service plan dated April 8, 2022, indicated R2 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, grooming, dietary, mobility, fall interventions, oral care, communication assist, emergency evacuation, activities and vital sign monitoring. On August 2, 2022, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medications. R2's Service Plan lacked the following required content: - the frequency of medication assistance; - the schedule of monitoring assessments of the resident; and - the method of monitoring staff providing services. R3 R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation].	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01650	Continued From page 61 R3's service plan dated July 26, 2022, indicated R3 received services which included behavioral management, incontinence care, toileting, night checks, medication administration, housekeeping, laundry, bathing, dressing, hygiene assistance, oral care, mobility, transferring, fall interventions, communication assist, emergency evacuation, activities and vital sign monitoring. R3's Service Plan lacked the following required content: - the frequency of medication assistance; - the schedule of monitoring assessments of the resident; and - the method of monitoring staff providing services. On August 3, 2022, at approximately 8:45 a.m., registered nurse (RN)-C verified R2 and R3's service plans were missing the above mentioned content. In addition, RN-C confirmed the same service plan template is used for all residents. The licensee's Service Plan policy revised August 1, 2021, indicated service plans would include the frequency of each service to be provided based on the most recent assessment and resident preferences, a schedule for the next planned assessment or monitoring, and the method for the next planed monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01700	Continued From page 62	01700		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) to determine what medication management services would be provided and included identification and review in	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01700	Continued From page 63 all required areas for one of two residents (R2) with records reviewed. 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 August 1, 2022, at 11:54 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. R2's diagnoses included, back pain, bipolar disorder, and mild cognitive impairment. R2's service plan dated April 8, 2022, indicated R2 received services which included medication administration. R2's prescriber orders dated November 3, 2021, included one atypical antipsychotic, one cognition enhancing medication, three health supplements and one lubricating eye drop. On August 2, 2022, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medications. R2's record lacked evidence the RN conducted a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01700	Continued From page 64 reactions, and actions to address these issues. In addition, R2's record lacked to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On August 3, 2022, at approximately 8:40 a.m., RN-C confirmed R2's record failed to include a review of medications with the required content. RN-C added, " I do them, and maybe other RN did it, but I can't find it." The licensee's Medication Management-Assessment, Monitoring & Reassessment policy revised August 1, 2021, indicated the review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. In addition, the assessment would identify interventions needed in management of medication to prevent diversion [misuse, theft, or illegal or improper disposition of medications] of medication by the resident or others who may have access to the medication and provide interactions to the resident and legal or designated representatives on interventions to manage the resident's medication and prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01730	Continued From page 65 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01730	Continued From page 66 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include specific resident instructions relating to medication administration for one of two residents (R3) with records reviewed. 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 April 18, 2022, at 10:00 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to residents at the facility. R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation]. R3's service plan dated July 26, 2022, indicated the resident received medication administration.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01730	Continued From page 67 R3's prescriber orders dated July 14, 2022, included the following medications: polyethylene glycol 17 grams (g) (constipation) mix in 8 oz. of water, juice, soda, coffee or tea prior to administration. R3's prescriber orders dated October 4, 2021, included Finasteride [benign prostate enlargement] 5 milligrams (mg) "DO NOT CRUSH". R3's Medication/Treatment/Therapy Management Plan dated September 9, 2021, stated specific client instructions relating to the administration of medication/treatments/therapy is located on the client's medication administration record (MAR). R3's MAR dated July 2022 lacked resident specific medication instructions. On August 3, 2022, at 10:40 a.m., RN-C stated, "Yes it [do not crush] should be there [MAR]." RN-C looked on the MAR and confirmed the MAR lacked to include specific instructions. "it is not on there, I am not seeing it". On August 3, 2022, at 10:40 am., RN-C verified R3's MAR lacked specific instructions to mix medication [polyethylene glycol] with 8 oz of water or juice. The licensee's Medication & Treatment-Administration & Delegation policy revised August 1, 2021, indicated the RN would include specified, in writing, specific instructions for each resident and document those instructions in the resident's records. No further information was provided.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01730	Continued From page 68 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure medications were transcribed as prescribed for one of two residents (R3) with records reviewed. 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).	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01760	Continued From page 69 The findings include: R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation]. R3's service plan dated July 26, 2022, indicated R3 received services to include medication administration. R3's prescriber orders dated March 2, 2022, included an order for duo (ipratropium bromide 0.5 milligrams (mg) and albuterol sulfate 3 mg, 3 milliliter (ml) nebs [drug delivery device used to administer medication in the form of a mist inhaled into the lungs] administer 1 vial, two times a day as needed (PRN) for COPD. R3's July 2022 medication administration record (MAR) included ipratropium-albuterol inhalation solution 0.5-2.5 mg/3 ml inhalation solution. Administer 1 vial (1) inhalation as needed. Follow up after 30 minutes. On August 3, 2022, at approximately 9:15 a.m., registered nurse (RN)-C confirmed R3's ipratropium-albuterol order was not transcribed correctly onto the MAR. The licensee's Medication & Treatment Record-Documentation & Refusal policy revised August 1, 2021, indicated the facility would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01760	Continued From page 70 and/or treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document all required content for medication setup for three of three residents (R7, R1, R8) receiving medication set up services with records reviewed. 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 August 1, 2022, at approximately 11:55 a.m., registered nurse (RN)-C confirmed the licensee provided medication management services to include	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01770	Continued From page 71 medication setup. On August 1, 2022, at approximately 12:15 p.m., a tour of the facility was conducted with RN-C, including a review of the locked medication cart located in the dining room area against a wall. The surveyor observed a seven-day medication planner labeled with R7's name in the medication cart. RN-C confirmed she put the medications in the seven-day medication planner. RN-C added, she does this until the pharmacy supplies them [facility] with dosage cards. The surveyor requested the documentation of the above noted medication planner, which had been setup for R7. In addition, two (2) small plastic bags were in the double locked narcotic compartment of the medication cart with R1 and R8's names on them. R7 R7's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, and route of administration. R7's diagnoses included dementia, colon cancer, hypertension (high blood pressure), major depressive disorder, vitamin B12 deficiency and general anxiety disorder. R7's Service plan dated July 23, 2022, indicated R7 received services including medication assistance. R7's prescriber orders dated July 26, 2022, included: - aspirin-low oral tablet delayed release 81 milligrams (mg) 8:00 p.m. - atorvastatin calcium (high cholesterol) 20 mg, 8:00 p.m.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01770	Continued From page 72 - B-complex/B12 1000 (health supplement) microgram (mcg) 8:00 a.m.; - D-3 2000 units, (health supplement) 50 mcg 8:00 p.m.; and - escitalopram oxalate (anti depression or anxiety) 10 mg, 8:00 a.m. On August 1, 2022, at 3:17 p.m., RN-C verified there was no documentation for the medication set up for R7. RN-C asked the surveyor, "I suppose you need it [medication set up documentation] for R1 and R8 also?" R1 R1's diagnoses included Parkinson's disease (long term degenerative disorder of the central nervous system that mainly affects the motor system), hypertension (high blood pressure), gout (buildup of urate crystals in the joint causing pain), low back pain, chronic kidney disease, insomnia, hyperlipidemia (high cholesterol). R1's Service Plan dated July 26, 2022, indicated R1 received services including medication assistance. R1's prescriber orders dated April 22, 2022, included: - morphine concentrate 20 mg/milliliter (ml); take 2 mg (0.1 mL) twice a day (BID) and every 1 hour as needed (PRN). R8 R8's diagnoses included Alzheimer's/vascular dementia, Parkinson's disease, malignant neoplasm of colon (colon cancer), Basal cell carcinoma of skin (type of skin cancer), squamous cell carcinoma of skin (type of skin cancer) and benign prostatic hyperplasia (non-cancerous enlarged prostate).	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01770	Continued From page 73 R8's Service Plan dated April 5, 2022, indicated R8 received services including medication assistance. R8's prescriber orders dated September 14, 2021, included: - morphine 2.5 mg every (q) morning (AM) buccal (between gums and cheek) for pain/dyspnea (labored breathing). On August 1, 2022, at 3:21 p.m., RN-C confirmed there was not medication set up documentation for R1 and R8's medication. The licensee's Medication Management-Administration & Setup policy revised August 1, 2021, indicated a licensed nurse would correctly and accurately document any medication setup provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01790	Continued From page 74 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01790	Continued From page 75 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed a comprehensive written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on August 1, 2022, at approximately 11:55 a.m., RN-C stated the licensee provided medication management services. On August 3, 2022, at approximately 9:30 a.m., RN-C stated she trained the staff to call her if this [medications to be sent with resident] service was needed and she would come in and take care of	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01790	Continued From page 76 it. RN-C confirmed there was not a written process in place. RN-C added the "old" RN would be available for backup if and when she was not available. The licensee's Medication Management-Planned & Unplanned Time Away policy revised August 1, 2021, indicated the RN had developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address; a. the type of container or containers to be used for the medications appropriate to the provider's medication system; b. how the container or containers must be labeled; c. the written information about the medications to be given to the resident or resident's representative; d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the mediations were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information; e. how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative; f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01790	Continued From page 77 personnel; g. how the unlicensed staff must document in the resident's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (R3) with records reviewed. 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 August 1,	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01830	Continued From page 78	01830		

2022, at approximately 11:55 a.m., registered nurse (RN)-C stated the licensee provided medication management services to the residents at the facility.

R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation].

R3's Service Plan dated July 26, 2022, indicated R3 received medication assistance to include medication administration.

R3's medication administration record (MAR) dated July 1, 2022, through August 2,2022, indicated the following medications were being administered:
-Colace 100 milligram (mg) (stool softener) 2 capsule administered once daily;
-doxazosin mesylate (high blood pressure) 4 mg administered once daily;
-finasteride (prostate enlargement) 5 mg administered once daily;
-ipratropium-albuterol (COPD)0.5-2.5 (3) mg/3 milliliter (ml) administered four times daily;
-oxygen per nasal cannula 3 liters;
-Refresh ophthalmic solution (dry eyes) administered twice daily.

R3 was admitted to Hospice on February 20, 2022, and discharged from Hospice on July 12, 2022.

R3's record contained an unauthenticated Medication List dated April 15, 2021, [one plus

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01830	Continued From page 79 years beyond the annual required renewal date] included all of the above listed medication except for ipratropium-albuterol, which was ordered on March 2, 2022. In addition, this list contained several medications that were not on R3's July and August 2022 MAR. R3's record also contained a Fax dated October 4, 2021, sent to medical provider requesting an eye medication which included a medication list and was authenticated by medication provider however, this list contained several medications which were not on R3's July and August 2022 MAR. On August 3, 2022, at 11:17 a.m., RN-C stated R3 was recently seen by a new medical provider. RN-C added she "thought" the new provider would have reviewed all of R3's current medications. RN-C confirmed R3's record lacked to include annual orders. The licensee's Medication & Treatment Orders-Renewal policy dated August 1, 2021, indicated medication and treatment/therapy orders would be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01880	Continued From page 80 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 1, 2022, at 12:13 p.m., the surveyor toured the facility with registered nurse (RN)-C, including a review of the medication refrigerator. The surveyor inquired about the current refrigerator temperature. RN-C looked around in the refrigerator, however, there was not a thermometer. The refrigerator contained two unopened bottles of latanoprost (glaucoma medication) for R4, R9 and an unopened vial of cyanocobalamin (vitamin B-12) 1000 milliliters (ml) for R6. On August 1, 2022, at approximately 12:15 p.m., RN-C verified the temperature of the medication refrigerator was not monitored and RN-C did not have temperature logs for the medication	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01880	Continued From page 81 refrigerator. RN-C added the temperature used to be monitored. The manufacturer's instructions for latanoprost eye drops dated September 16, 2015, indicated the drop solution should be stored at 36-46 degrees F. The manufacturer's instructions for cyanocobalamin dated July 2020, indicated the solution should be stored at 68-77 degrees F. The licensee's Medication Storage policy revised August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for one of four residents (R5).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01890	Continued From page 82 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: On August 1, 2022, at 12:16 p.m., the surveyor toured the facility with registered nurse (RN)-C, including a review of the locked medication cart located in the dining room area against a wall. R5's unopened bottle of nitroglycerin 0.4 milligrams (mg) (used to treat and prevent chest pain) had expired June 29, 2022. On August 1, 2022, directly following the above observation, at 12:16 p.m., RN-C verified R5's nitroglycerin had expired. The licensee's Medication Storage policy revised August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 83 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of all medications to include the medication strength, prescription number, and quantity for all medications for one of one discharged resident (R10) with records reviewed. 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:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 84 R10 was admitted for services on January 14, 2022 and discharged on April 2, 2022. R10's service plan dated February 16, 2022, indicated the resident received medication assistance, which included medication administration. R10's medication administration record (MAR) dated March 2022, included the following medications: apixaban (anticoagulant) 2.5 milligrams (mg) twice a day, aspirin 81 mg, 8:00 a.m., atorvastatin calcium (high cholesterol) 10 mg, 8:00 a.m., cyanocobalamin (heath supplement)1000 microgram (mcg) 8:00 a.m., Breo Ellipta (chronic obstructive pulmonary disease (COPD) aerosol power 200-25 mcg inhalation 8:00 a.m., budesonide (COPD) inhalation 0.5 mg/2 milliliter (ml) twice a day, ferrous sulfate (amentia) 325 mg 8:00 a.m., fluticasone propionate (nasal symptoms) 50 mcg 1 puff 8:00 p.m., folic acid (vitamin) 1 mg 8:00 a.m., furosemide (diuretic) 20 mg 8:00 a.m., gabapentin (nerve pain) 300 mg twice a day, ipratropium-albuterol (COPD) 0.5-2.5 mg/3 ml twice a day, l-lysine (amino acid) 500 mg 8:00 a.m., losartan potassium (high blood pressure) 25 mg twice a day, melatonin (sleep aide) 3 mg 8:00 pm, metoprolol succinate (high blood pressure or chest pain) 50 mg 8:00 a.m., niacin (vitamin) 500 mg 8:00 p.m., omega III (vitamin) 1000 mg 8:00 a.m. pantoprazole sodium (reflux) 40 mg 8:00 a.m., thera-M plus (vitamin) 8:00 a.m., and polyethylene glycol (bowel health) 17 gram 8:00 am every other day. R10's prescriber orders dated February 7, 2022, included all of the above noted medications.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 85 R10's record lacked documentation for the disposition of the medications listed above. On August 2, 2022, at approximately 9:15 a.m., registered nurse (RN)-C verified she had not documented in R10's record a disposition of the medication. The licensee's Medication Disposal policy revised August 1, 2021, indicated the facility would document in the resident's record the disposition of the mediations including the medications name, strength, prescription number as applicable, quantity, to whom the medication was given, date of disposition, and names of staff and other individuals involved in the deposition. In addition, controlled substances must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01940	Continued From page 86 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content for one of one resident (R3). 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:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01940	Continued From page 87 On August 1, 2022, at approximately 11:55 a.m., during the entrance conference, registered nurse (RN)-C confirmed the licensee provided treatment and therapy services to residents as prescribed. R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation] On August 2, 2022, at 6:46 a.m., the surveyor observed unlicensed personnel (ULP)-B apply compression stockings (TEDs) to R3's lower extremities and adjust R3's nasal cannula (a hollow tube with two prongs that are placed into the nares to supply oxygen). R3's service plan dated July 26, 2022, did not identify R3 received assist with TEDs or oxygen. R3's record lacked evidence of an individualized treatment or therapy management plan which included the following for TEDS and oxygen administration. - documentation of specific resident instructions relating to the treatments or therapy administered; - identification of treatment or therapy tasks that would be delegated to ULP; - procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01940	Continued From page 88 administered as prescribed; and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 3, 2022, at 10:01 a.m., RN-C verified a treatment plan had not been developed for R3. The licensee's Medication & Treatment Orders policy revised August 1, 2021, indicated a description of the treatment or therapy to be provided and the frequency, duration, and other information needed to carryout would be included in the order and the resident's treatment administration record (TAR) would be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01950	Continued From page 89	01950		

the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure prior to delegating treatments, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the treatments for one of one employee (ULP-B) with records reviewed.

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:

On August 1, 2022, at approximately 11:55 a.m., during the entrance conference, RN-C confirmed the licensee provided treatment and therapy services to residents as prescribed.

R3's diagnoses included, dementia, hypertension (high blood pressure), ischemic stroke (when blood vessels to the brain become clogged), chronic kidney disease (CKD), anxiety, oxygen dependent, and chronic obstructive pulmonary disease (COPD) [a progressive lung disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
01950	Continued From page 90 characterized by long-term respiratory symptoms and airflow limitation]. R3's service plan dated July 26, 2022, did not identify R3 received assistance with compression stockings (TEDs). On August 2, 2022, at 6:46 a.m., the surveyor observed ULP-B lotion R3's legs, remove R3's slippers, and apply TEDs to R3's legs. On August 3, 2022, at 10:17 a.m., ULP-B stated he learned about TEDs from a certified nursing assistance (CNA) not a RN. On August 3, 2022, directly following the above interview, RN-C confirmed newly hired staff are scheduled to work on the floor with another staff personnel prior to RN training. RN-C added they are supposed to just shadow. RN-C stated she later works with the newly hired staff on a weekend. RN-C verified she did not train ULP-B on the delegated task of TEDs. The licensee's Competency Training Evaluations policy revised August 1, 2021, indicated when a RN delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02110	Continued From page 91	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02110	Continued From page 92 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives for all residents currently receiving services by the licensee. 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 was licensed as an Assisted Living with Dementia Care facility on August 1, 2021, with a capacity and current census of 16 residents. On August 2, 2022, at 3:17 p.m., registered nurse (RN)-C verified none of the residents and/or legal representatives received the inclusive list of dementia care policies and procedures as required at the time of move-in to the facility. The licensee's Assisted Living with Dementia Care Additional Required Policies policy revised August 1, 2021, indicated these [dementia] policies and procedures would be provided to residents and the resident's legal and designated representatives at the time of move-in. The policies could be provided in electronic format if desired.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02110	Continued From page 93 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with bedrails. 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: The licensee's registered nurse (RN) failed to conduct a complete assessment for a bed rail to include the purpose of the bedrail. On August 2, 2022, at 7:09 a.m., the surveyor observed R1 positioned on his left side facing the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02310	Continued From page 94	02310		

wall. R1's hospital bed was against the wall and had an upper bedrail on the side of the bed facing the room. The side rail was secured to the bed and in the upright position. The surveyor observed unlicensed personnel (ULP)-D place a syringe of medication into R1's mouth.

On August 2, 2022, at 7:50 a.m., the surveyor observed licensed practical nurse (LPN)-E and ULP-D raise the hospital bed, lowered the bedrail, and use a sit to stand lift to assist R1 out of bed.

R1's diagnoses included Parkinson's disease (long term degenerative disorder of the central nervous system that mainly affects the motor system), hypertension (high blood pressure), gout (buildup of urate crystals in the joint causing pain), low back pain, chronic kidney disease, insomnia, hyperlipidemia (high cholesterol).

R1's Service Plan dated July 26, 2022, indicated R1 received services including behavioral management, incontinence care, toileting, night checks, health monitoring: housekeeping, mobility, transferring, fall interventions, laundry, bathing, grooming, oral, shaving, eating, medication assistance, emergency evacuation, and leisure/hobbies/interests/individual activities and vital sign monitoring.

R1's Service Plan dated July 26, 2022, fall interventions included:
- shoes on while out of bed;
- room and hallways free of clutter;
- side rail on right side of bed up while in bed; and
- night light on nights (NOC).

R1's Fall Risk Assessment dated March 8, 2021, (per RN-C, fall risk assessment was completed after recent fall) included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02310	Continued From page 95 - Cognitive Status/Behavior Indicators: Periods of altered perception or awareness of surroundings, periods of restlessness, mental function varies over the course of the day, resist cares-2; - Vision Status: Moderately impaired- limited vision, but can identify objects-2; - Continence: Elimination with assistance-2; - Mobility: Ambulates with problems and with devices-4; - Balance: Always needs physical support -4; - Systolic Blood Pressure and vitals- no drop in pressure noted-0; - Health Conditions: Neuromuscular or functional (loss of arm/leg movement, hypotension [low blood pressure], Parkinson's, loss of sensation, Orthopedic (joint pain, hip fracture, missing limb, osteoporosis), psychiatric or cognitive (delirium, Alzheimer's disease, dementia)-4; - Medication: Antipsychotics, antidepressants, antihypertensives-4; - Total Score 32; Fall Risk Score = 7+ Higher Risk. Fall Risk Assessment authenticated May 24, 2021, at 3:35 p.m., by RN-C. R1's Side Rail assessment dated April 9, 2022, authenticated April 11, 2022, and July 11, 2022, (91 days apart) included: -zone 1, zone 2, and zone 3 measurements; (within U.S. Food and Drug Administration (FDA) guidelines). -education provided to family; and -signature of nurse and responsible party. The Side Rail assessment lacked intended purpose of side rails. On August 2, 2022, at approximately 7:52 a.m., the surveyor interviewed LPN-E regarding the side rail. LPN-E stated, "he used to have alarms, went down to bed rails. He moves around a lot".	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02310	Continued From page 96 On August 2, 2022, at 10:00 a.m., ULP-D indicated bed rails were used for R1, "when he is in bed, to keep him in bed and to keep him from moving around too much". On August 2, 2022, at approximately 10:15 a.m., RN-C said R1 had alarms and bedrails both for a while however the alarm was removed. RN-C stated, when he got the hospital bed, it [hospital bed] came with rails so they [facility] used them, "tried them". RN-C added she had spoken to R1's wife and she was in agreement about them [bed side rails]. The surveyor interviewed RN-C regarding the purpose of R1's rails. RN-C replied, "To keep him from falling. I don't know anyway else to describe it." On August 2, 2022, at approximately 10:20 a.m., RN-C stated side bed rails at night were started March 8, 2022. The licensee's Side Rails policy revised August 1, 2021, indicated when side rails ware in use, an RN must conduct an assessment to identify the intended purpose of the side rails and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(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
02310	Continued From page 97 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, and interview the licensee failed to ensure signage was posted at the main entry of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 16 residents, staff and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34745	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MOORHEAD	1001 CADDY AVENUE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 98 Findings include: On August 1, 2022, at 11:33 a.m., the surveyor entered the facility and observed no signage posted at the entrance or areas immediately adjacent to the entry regarding electronic monitoring. On August 1, 2022 at 11:44 a.m., registered nurse (RN)-C verified they had not posted a sign to disclose electronic monitoring activity. RN-C confirmed four cameras were in the building: two down hallways, one in the entry, one in the medication/staff area. The licensee's Electronic Monitoring policy revised August 1, 2021, confirmed signs would be installed at each facility entrance accessible to visitor that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

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

Type: Full
Date: *08/02/22*
Time: 12:00:32
Report: 1008221037

Food and Beverage Establishment Inspection Report

Location:
Beehive Homes Of Moorhead
1001 Caddy Avenue
Moorhead, MN56560
Clay County, 14

Establishment Info:
ID #: 0038676
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185123033
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

Raw eggs shall be stored on lowest shelf in cooler. eggs were on top shelf above ready to eat foods.

Corrected on Site

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 CONCENTRATION OF BLEACH IN THE SANITIZER BUCKET WAS HIGHER THAN ALLOWED, 200+ppm. THE SANITIZER BUCKET WAS REMADE DURING THE INSPECTION TO AN APPROVED LEVEL, 100ppm.

Corrected on Site

4-200 Equipment Design and Construction

4-204.115 ** Priority 2 **

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

PROVIDE A TEMPERATURE MEASURING DEVICE FOR THE UNDERCOUNTER DISH MACHINE.

Comply By: 08/09/22

4-500 Equipment Maintenance and Operation

4-501.116 ** Priority 2 **

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

No sanitizer test strips were available to test concentration of sanitizer being used. Provide chlorine test strips.

Comply By: 08/09/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CURRENTLY ESTABLISHMENT EMPLOYEES NO CFPM. HAVE AT LEAST ONE CFPM.

Comply By: 08/30/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Remove all domestic equipment (non ANSI certified): 2 Instant pots, Crock pot brand pressure cooker, blender, snow cone maker, Ice cream machine, waffle maker Cuisinart food processor, griddle, Frigidaire ice machine, Kitchen aid mixer.

Comply By: 08/09/22

Surface and Equipment Sanitizers

Chlorine: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: Yes

Chlorine: = 100 at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler - Single Do
Temperature: 41 Degrees Fahrenheit - Location: MILK COOLER NEXT TO HAND SINK
Violation Issued: No

Process/Item: Upright Cooler - Single Do
Temperature: 40 Degrees Fahrenheit - Location: HAM
Violation Issued: No

Process/Item: Steam Table
Temperature: 174 Degrees Fahrenheit - Location: MEATBALLS
Violation Issued: No

Type: Full
Date: *08/02/22*
Time: 12:00:32
Report: 1008221037
Beehive Homes Of Moorhead

Food and Beverage Establishment Inspection Report

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

THINGS TO REMEMBER:

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

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

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

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1008221037 of 08/02/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1088

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

Report #: 1008221037

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	2	**Date**	08/02/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:00:32
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Beehive Homes Of Moorhead	1001 Caddy Avenue	Moorhead, MN	56560	2185123033

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0038676		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	X	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used	X	
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) emailed to HRD **Date:** 08/03/22

Inspector (Signature) Inspector ID# 10082