Electronically Delivered

June 8, 2022

Administrator
Beka Home Inc
9101 Nevada Court
Brooklyn Park, MN 55445

RE: Project Number SL36945015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 24, 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, no immediate fines are assessed.

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

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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36945	A. BUILDING: _____ B. WING _____	05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEKA HOME INC	9101 NEVADA COURT BROOKLYN PARK, MN 55445

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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#36945015-0 On May 23, 2022, through May 24, 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 three residents, all of whom received services under the provider's Assisted Living License.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's three 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: Registered Nurse (RN)-A obtained an assisted living director license on September 17, 2021. On May 23, 2021, at approximately 9:56 a.m., the surveyor observed the Board of Executives for Long-Term Services and Support (BELTSS) website indicated RN-A held a current assisted living director license but was not listed as Director of Record for the licensee. On May 23, 2022, at approximately 10:30 a.m., during the entrance conference, registered nurse (RN)-A identified themself as the LALD for the licensee.	0 110		

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0 110	Continued From page 2 On May 23, 2022, at approximately 10:43 a.m., RN-A verified they were not listed as the Director of Record for the licensee and would contact BELTSS for correction. In addition, RN-A stated they believed BELTSS listed them on the incorrect facility as Director of Record. TIME PERIOD FOR CORRECTION: Two (2) days The licensee provided the surveyor evidence the correction was made during the survey on May 24, 2022.	0 110		
0 430 SS=C	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; (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).	0 430		

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0 430	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of one resident (R1) with record 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 admitted for service on March 15, 2022, and began receiving assisted living services. R1's Service Plan dated March 15, 2022, indicated R1 received assistance with medication administration, laundry and nursing assessments. R1's record included Statement of Home Care Services: Comprehensive Home Care Provider dated March 15, 2022. R1's record lacked a UDALSA to include: - a disclosure of the categories of assisted living 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.	0 430		

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0 430	Continued From page 4 On May 23, 2022, at 12:00 p.m., registered nurse (RN)-A provided surveyor a document titled Statement of Home Care Services: Comprehensive Home Care Provider and stated the document was given to all residents when they admitted to the licensee. On May 23, 2022, at approximately 1:09 p.m., RN-A verified R1's record lacked a UDALSA and acknowledged document titled Home Care Services: Comprehensive Home Care Provider provided to residents upon admission was for a comprehensive home care license. RN-A stated the documents were not changed when the new assisted living licensure went into effect. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance	0 460		

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0 460	Continued From page 5 notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 the residents). The findings include: On May 23, 2022, at approximately 9:30 a.m., the surveyor observed no system in place for residents to request staff assistance when needed 24 hours a day. On May 23, 2022, at approximately 10:37 a.m., registered nurse (RN)-A verified the licensee lacked a system for residents to request staff assistance when needed 24 hours a day. RN-A stated residents were independent with mobility and walk out of their rooms to ask for assistance. In addition, RN-A and housing manger (HM)-C stated staff observe residents every 2 hours to ensure the residents needs are being met. No further information was provided.	0 460		

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0 460	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 480		

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0 480	Continued From page 7 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated May 23, 2022. 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		

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0 485	Continued From page 8 Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all three residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 9:30 a.m., the surveyor observed the menu plan on refrigerator dated May 16, 2022, to May 22, 2022. The observed menu was not prepared at least one week in advance. On May 23, 2022, at approximately 9:40 a.m., unlicensed personnel (ULP)-B stated the menu was not changed to reflect the upcoming week. On March 23, 2022, at approximately 10:02 a.m., housing manager (HM)-C stated the menu was normally made available to residents weekly. HM-C verified the menu was not 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		

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0 550	Continued From page 9	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all three residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances.	0 550		

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0 550	Continued From page 10 On May 23, 2022, at approximately 9:30 a.m., the surveyor observed the common areas shared by residents, staff and visitors lacked the required posting of the grievance procedure. On May 23, 2022, at approximately 1:35 p.m., housing manager (HM)-C verified the required content was not posted in the common areas. HM-C stated residents are provided the grievance information at admission on a form. In addition, HM-C stated residents have case managers they can discuss concerns with, and HM-C asked residents if they had concerns and addressed the issues. The licensee's Complaints policy dated August 1, 2021, indicated the licensee would post in a visible location information about the facility's grievance procedure and would include the name, telephone number and email for the individuals responsible for handling resident grievances. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;	0 640		

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0 640	Continued From page 11 (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 support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all three 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 potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at 9:30 a.m., the surveyor observed the facility's main entry area and common areas lacked the required posted information as followed: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment	0 640		

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0 640	Continued From page 12 of a vulnerable adult under section 626.557. On May 23, 2022, at approximately 10:07 a.m., housing manager (HM)-C verified the required content noted above had not been posted. HM-C stated residents are provided with MAARC information on a form when admitted to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 680		

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	36945	A. BUILDING: _____ B. WING _____	05/24/2022

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0 680	Continued From page 13 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all three residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 9:30 a.m., during a facility tour, the surveyor observed the licensee lacked evidence of signage posted or information regarding the licensee's emergency plan. There were no emergency exit diagrams posted in conspicuous places on each floor as required. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - current, all-hazards approach facility	0 680		

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0 680	Continued From page 14 assessment; - a description of the population served by the licensee; - staffing surges/shortages; - subsistence needs for staff and residents; - procedure for medical documents; - procedure for volunteers; - policies and procedures for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - names and contact information; - emergency official contact information; - alternate means for communication; and - methods for sharing information. On May 23, 2022, at 10:19 a.m., registered nurse (RN)-A and housing manager (HM)-C acknowledged the facility lacked emergency exit diagrams. RN-A stated the licensee did not believe exit diagrams were required because of a result from a previous survey. In addition, RN-A stated residents participated in fire drills and how to exit the facility. On May 24, 2022, at 9:54 a.m., RN-A acknowledged emergency preparedness plan lacked the content above. The licensee's Handling of Emergencies and use of Emergency Services policy, dated August 1, 2021, indicated emergency exit diagrams would be provided to all residents and posted on each floor. In addition, the licensee would have a communication plan that would include contact information of the following: - entities providing services; - resident's physicians; - other facilities; - volunteers; - federal, state, tribal, regional and local	0 680		

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0 680	Continued From page 15 emergency preparedness staff; - state licensing and certification agency; - state office of the Long-Term Care Ombudsman; - facility staff; and - federal, state, tribal, regional and local emergency management agencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 16 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 residents). The findings include: On May 24, 2022, from approximately 10:45 a.m. to 11:30 a.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed there were no portable fire extinguishers on-site at the time of the survey. HM-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800		

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0 800	Continued From page 17 and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On May 24, 2022, from approximately 10:45 a.m. to 11:30 a.m., survey staff toured the facility with the housing manager (HM)-C. During the facility tour, survey staff observed the following: 1. The upstairs bathroom fan was covered in lint and dust, the sealant at the shower was black and molding at the top of the bathtub, and the sealant at the sink was stained in some areas and damaged in some areas. 2. The downstairs bathroom fan was covered in lint and dust, and the light over the shower did not work. 3. In the under stair storage closet there was a large hole in the ceiling around a duct. HM-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required fire safety	0 810		

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0 810	Continued From page 19 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: During interview on May 24, 2022, at 11:30 a.m., the registered nurse (RN)-A stated they have done fire safety training for staff on in-service days. RN-A stated in-service days happen once a month and can be customized to include any topic. Review of the fire safety and evacuation policy showed the following: 1. Language for fire drills stated "drills will be done every six months" which does not comply with the statute. The record of evacuation drills shows the licensee was doing them in compliance with the statute, but the policy is outdated. 2. Licensee had R.A.C.E. procedures in place but did not have any documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation, especially for residents who are	0 810		

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0 810	Continued From page 20 wheelchair-bound and need assistance during an evacuation. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 5. Posted evacuation plan was difficult to read and inaccurately drawn. Licensee requested example egress plans for guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional	0 920		

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0 920	Continued From page 21 fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 12:00 p.m., the registered nurse (RN)-A provided a blank service agreement and stated the contract was used by the licensee for all residents. The service agreement lacked a disclosure of the facility's ability to provide specialized diets. R1's Service Agreement dated March 15, 2022, lacked a disclosure of the facility's ability to	0 920		

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0 920	Continued From page 22 provide specialized diets. On May 23, 2022, at 1:03 p.m., RN-A verified the contract lacked disclosure of specialized diets and disclosure of the category of assisted living facility license held by the facility. RN-A stated the licensee was not aware of the requirement, and the service agreement had been reviewed by the Ombudsman and case workers who had not mentioned missing content. In addition, RN-A stated licensee had been revising the current contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the	0 940		

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0 940	Continued From page 23 housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for one of one resident (R1) with record 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 12:00 p.m., the registered nurse (RN)-A provided a blank service agreement and stated the contract was used by the licensee for all residents. The service	0 940		

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0 940	Continued From page 24 agreement lacked the following content: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. R1 admitted to licensee on March 15, 2022. R1's Service Agreement signed March 15, 2022, lacked the following content: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover	0 940		

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0 940	Continued From page 25 the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On May 23, 2022, at approximately 1:06 p.m., RN-A verified the contract lacked the above content. RN-A stated the licensee was not aware of the requirement, and the service agreement had been reviewed by the Ombudsman and case workers who had not mentioned missing content. In addition, RN-A stated licensee had been revising the current contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=F	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	0 950		

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0 950	Continued From page 26 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 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1) with record 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 May 23, 2022, at approximately 12:00 p.m., the registered nurse (RN)-A provided a blank	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36945	A. BUILDING: _____ B. WING _____	05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEKA HOME INC	9101 NEVADA COURT BROOKLYN PARK, MN 55445

(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 27 service agreement and stated the contract was used by the licensee for all residents. The service agreement lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. R1's Service Agreement signed March 15, 2022, lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On March 23, 2022, at 11:59 a.m. registered nurse (RN)-A verified the right to designate a representative form was not in the resident service agreements. RN-A stated if a resident designated a representative, it would be written in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 28 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470		

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01470	Continued From page 29 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (registered nurse (RN)-A, and unlicensed personnel (ULP)-B) received orientation to assisted living facility licensing requirements and regulations 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: RN-A had a hire date of January 1, 2021. ULP-B had a hire date of April 27, 2022. RN-A and ULP-B's employee records lacked evidence to indicate the employees had received orientation to include the following topics: - review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01470		

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01470	Continued From page 30 On May 23, 2022, at approximately 1:19 p.m., RN-A verified the employee's records lacked the content listed above. RN-A stated staff had participated in an in-service last year when the assisted living licensure began however, RN-A was unable to find documentation of content listed above. The licensee's Assisted Living Statute and Rule Overview policy, dated August 1, 2021, indicated personnel would receive required content for orientation and annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530		

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01530	Continued From page 31	01530		

dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to provide evidence of dementia care training on required topics for one of three employees (unlicensed personnel (ULP)-D) 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-D's record lacked documentation of the required eight (8) hours of dementia training within 120 working hours of the employment start date.

ULP-D's hire date was April 23, 2021.

ULP-D's record included one Certificate of Completion dated May 21, 2022, for Ethics in Dementia Care which indicated the training

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01530	Continued From page 32 qualified for one hour of continuing education. On May 24, 2022, at 10:19 a.m., registered nurse (RN)-A verified ULP-D's record lacked 8 hours of dementia training within 120 hours of the employment start date. RN-A stated the licensee provided dementia training through an online company and had requested ULP-D complete the training. In addition, RN-A stated ULP-D was working on-call which made it challenging to complete dementia training. The licensee's Assisted Living Statute and Rule Overview policy, dated August 1, 2021, indicated direct care employees must have completed 8 hours of dementia training within 160 hours of start date and cannot provide direct care until initial training is completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days 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	01620		

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01620	Continued From page 33 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day comprehensive reassessment using the uniform assessment tool for one of one resident (R1) as required with record 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: R1 admitted to licensee on March 15, 2022. R1's Service Plan dated March 15, 2022, indicated R1 received services for medication administration, laundry, housekeeping and nursing assessments.	01620		

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01620	Continued From page 34 R1's record included a Nurse Monitoring and Reassessment dated March 29, 2022. The Nurse Monitoring and Reassessment indicated R1 required assistance with medication administration, laundry, housekeeping and dietary but lacked the following areas of the uniform assessment tool: - resident's personal lifestyle preferences; - activities of daily living; - physical health status; - emotional and mental health conditions; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; and - risk indicators. On May 24, 2022, at 10:19 a.m., RN-A verified R1's Nurse Monitoring and Reassessment lacked the above content from the uniform assessment tool. RN-A stated licensee was unaware of requirement. In addition, RN-A stated the Nurse Monitoring and Reassessment form was used for all 14-day and 90-day reassessments for all residents. The licensee's Assisted Living Statute and Rule Overview policy, dated August 1, 2021, indicated reassessment would occur 14 days after initiation of services, and then every 90 days thereafter or with any significant change. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01910	Continued From page 35	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the 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 medication to include the medication name, strength, prescription number, and quantity for one of two discharged 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	01910		

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01910	Continued From page 36 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 discharged from licensee on August 16, 2021. R3's Service Plan dated January 12, 2021, indicated R3 received services for medication administration, personal laundry and nursing services. R3's medication administration record (MAR) dated August 31, 2021, included the following medications: olanzapine 10 milligrams (mg), olanzapine 20 mg, haloperidol 300 mg, benztropine 0.5 mg and haloperidol 5mg. R3's record lacked evidence of documentation of R3 disposition of medications to include name of the medication name, strength, prescription number and quantity. On May 23, 2022, at 1:50 p.m., registered nurse (RN)-A verified R3's record lacked a complete medication disposition. RN-A stated when residents discharge, staff write the remaining amount of medication on the top of the medication card and then have the resident sign off it was given to them. The licensee's Discharge and Transfer of Residents policy, dated August 1, 2021, indicated a resident would receive a reconciliation of all predischarge medications with the residents post discharged prescribed and over the counter medications. No further information was provided.	01910		

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01910	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *05/23/22*
Time: 12:23:19
Report: 8058221099

Food and Beverage Establishment Inspection Report

Location:
Beka Home Inc
9101 Nevada Court
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0037811
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638988319
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.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE MARKING OF ITEMS - COS

Comply By: 05/23/22

2-100 Supervision

2-102.12AMN

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

NO CFPM POSTED

Comply By: 06/30/22

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: STEW
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *05/23/22*
Time: 12:23:19
Report: 8058221099
Beka Home Inc

Food and Beverage Establishment Inspection Report

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

HRD INSPECTOR - ASHLEY CREWS
ESTABLISHMENT REP - NAS NURE

ESTABLISHMENT IS A RESIDENTIAL HOME SET IN A RESIDENTIAL NEIGHBORHOOD HOUSING A SMALL NUMBER OF PEOPLE

STAFF PREPARES FOOD

EQUIPMENT IS RESIDENTIAL

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 8058221099 of 05/23/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____ Establishment Representative

Signed:_____

Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us