



Protecting, Maintaining and Improving the Health of All Minnesotans

February 25, 2022

Administrator
Beatitudes Homes, LLC
1609 84th Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37087015

Dear Administrator:

On February 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 7, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is back in compliance./ in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Jess Gallmeier'. The signature is fluid and cursive, with the first name 'Jess' and last name 'Gallmeier' clearly distinguishable.

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 31, 2022

Administrator
Beatitudes Homes LLC
1609 84th Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37087015

Dear Administrator:

On December 17, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 7, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 7, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 7, 2021, found not corrected at the time of the December 17, 2021 follow-up evaluation and subject to penalty assessment are as follows:

0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7 - \$500.00

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 - \$500.00

1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3

The details of the violations noted at the time of this follow-up evaluation completed on December 17, 2021 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on December 17, 2021, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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.

We urge you to review these orders carefully. If you have questions, please contact Jessica Gallmeier at 651-247-0268 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jessica Gallmeier", written in dark ink.

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 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: Project # SL37087015 On December 16, 2021, through December 17, 2021, an evaluator of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 7, 2021. At the time of the survey, there were three active residents receiving services under the Assisted Living license.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by	0 110		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 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 employment of a licensed assisted living director (LALD). This had the potential to affect all the 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 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 an LALD to manage and supervise the assisted living services for the current residents receiving assisted living services. On December 16, 2021, at 2:55 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed for verification of the assisted living director licensure. Owner (O)-A was not listed as having a current LALD license. Administrator (A)-G was not listed as having a current LALD license. During an interview on December 16, 2021 at approximately 2:45 p.m., O-A stated their LALD application was being processed by BELTSS.	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 During an interview on December 16, 2021, at 3:10 p.m., A-G confirmed her licensure application for assisted living director was still pending with BELTSS and that she was scheduled to take a course at the University of Minnesota. The licensee's policy, titled Assisted Living Director, dated October 11, 2021, indicated the Beatitudes Homes is required to have an Assisted Living Director licensed or permitted by the BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days Immediacy is removed as confirmed by evaluation supervisor on January 12, 2022, however noncompliance remains at a scope and severity of F.	0 110		
{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.	{0 550}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
{0 550}	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. 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: On December 16, 2021, at approximately 2:50 p.m., during the building tour, the licensee lacked a posting of the above required content in a conspicuous place. On December 16, 2021, at approximately 2:20 p.m., owner (O)-A confirmed the content had not been posted as required. The licensee's Complaint/Grievance policy, dated October 11, 2021, lacked the verbiage to include the content of required postings. No further information was provided.	{0 550}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
{0 630}	Continued From page 4	{0 630}			
{0 630} SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an individualized abuse prevention plan (IAPP) with specific measures to reduce risk of abuse and lacked inclusion of known vulnerabilities for two of three residents (R1 and R4) 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 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: R1's diagnoses included diabetes, major depressive disorder, hypertension and	{0 630}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
{0 630}	Continued From page 5 polyneuropathy (nerve disease causes weakness, numbness, burning pain.) R1's Service Plan, dated December 8, 2021, indicated R1 received services that include staff assistance with behavior management, medication administration, blood glucose monitoring and safety checks. R1's IAPP, dated November 8, 2021, indicated vulnerabilities including self-abuse, history of suicidal thoughts, and risk of getting abused. The intervention noted "monitor closely," but did not identify when to monitor resident. R4's diagnoses included mood disorder, major depressive disorder, cognitive impairment, impulse control disorder, bipolar disorder, suicidal ideation and polysubstance abuse. R4's Service Plan, dated November 8, 2021, indicated R4 received services including staff assistance with behavior management, medication administration, vital sign monitoring, cleaning, and decluttering. R4's IAPP dated, August 11, 2021, indicated R4 was vulnerable and at risk of abuse to self and others due to attempted suicide during the past nine months. Interventions included medication management and a daily safety check. R4's IAPP lacked detail of specific interventions to prevent suicide. During an interview on December 17, 2021, at approximately 10:40 a.m., registered nurse (RN)-C acknowledged the interventions were not clear and stated R1 had his own vehicle and directed his own schedule. RN-C stated she will update the IAPP for all residents.	{0 630}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
{0 630}	Continued From page 6 The licensee's policy IAPP requested but not provided No further information was provided.	{0 630}		
{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	{0 810}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 7 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy management 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 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	{01940}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 8 changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments had specific resident instructions relating to the treatments and when to notify a registered nurse (RN) when problems arose 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, 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: R1's diagnoses included diabetes. R1's Service Plan dated November 8, 2021, indicated R1 received services that included staff assistance with blood glucose (BG) monitoring daily. R1's physician orders dated December 9, 2021 indicated R1 required assistance with BG monitoring daily. R1's BG log, dated August 2021, indicated R1 did not have BG record result on August 4, August 10, August 11, and August 24. R1's BG results ranged from 90-327. R1's BG log, dated September 2021, indicated R1 did not have a BG record result on September	{01940}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/17/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 9 1, September 6, September 7, September 8, September 10, September 11, September 12, September 13, September 15, September 16, September 17, September 18, September 19, September 20, September 21, September 22, September 23, September 24, September 27, September 28, September 29, and September 30. R1's BG results ranged from 150-292. R1's treatment and therapy plan lacked the acceptable blood glucose parameters for R1. During an interview on December 17, 2021, at approximately 10:00 a.m., RN-C acknowledged R1 was missing specific BG parameters and stated she did request for the specific BG parameters for R1 but the physician had not responded. She also stated the R1 was not available most of the time for his treatment. The licensee's Physician Orders policy, dated Dec 1, 2019, indicated all medically delegated services were required to be under a prescriber's order. A written order for all medications and treatments must be signed and dated by the provider. The RN was responsible for implementing all treatment orders and for delegation to ULP. No further information was provided.	{01940}		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2021

Administrator
Beatitudes Homes LLC
1609 84th Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37087015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 7, 2021, 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 Home Care 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 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), immediate fine imposition is authorized for both surveys and investigations conducted. 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:

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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 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,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 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: SL37087015 On October 5, 2021, through October 7, 2021, 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 four residents receiving 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 1 (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). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for one of two residents (R1) 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 2 R1's record lacked a uniform disclosure of assisted living services and amenities (UDALSA) checklist 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 of 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. On October 5, 2021, at approximately 10:40 a.m., during observation, unlicensed personnel (ULP)-B administered morning medications to R1. R1's Master Care Plan dated August 11, 2021, indicated diagnoses to include; diabetes, acute leg pain, hypertension, and major depressive disorder. R1's Service Plan dated March 27, 2021, indicated R1 received services to include medication administration, behavior management, monitor blood glucose and blood pressure, grooming, activity assistance, nail care, meal preparation, laundry and housekeeping. On October 6, 2021, at approximately 10:40 a.m., owner (O)-A confirmed R1 and all other residents who received services under the assisted living license had not received a written checklist that listed all services provided under the facility's assisted living license, and the services not provided under the facility's license. The licensee lacked policies to include the new	0 430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 3 Assisted Living Licensure requirements, effective August 1, 2021. 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, 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;	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing plan was posted as required. This had the potential to affect all four 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: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. (ii) Always ensures sufficient staffing 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. On October 5, 2021, at approximately 10:30 a.m., during the building tour, surveyor observed a board with postings that included; the assisted living license, the assisted living director's license	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 5 and a Clinical Laboratory Improvement Amendment (CLIA), but the staffing plan was missing. On October 6, 2021, at approximately 3:00 p.m., owner (O)-A stated a staffing plan had not been developed to address the content listed above, as they were not aware of the new regulations. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. 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	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to adhere 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Report dated, October 5, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance 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	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 550	Continued From page 7 to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facilities' grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors and all four 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 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: On October 5, 2021, at approximately 10:50 a.m., during facility tour, the licensee lacked a posting of the above required content in a conspicuous place. On October 6, 2021, at approximately 1:20 p.m., owner (O)-A confirmed the content had not been posted as required. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 550	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an individualized abuse prevention plan (IAPP) with specific measures to reduce risk of abuse and lacked inclusion of known vulnerabilities for two of four residents (R1, R4) with records reviewed. This practice had the potential to affect all four 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 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).	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 630	Continued From page 9 The findings include: R1's Service Plan dated March 27, 2021 indicated R1 received services that include staff assistance with behavior management, medication administration, blood glucose monitoring and safety checks. R1's diagnoses included diabetes, major depressive disorder, hypertension and polyneuropathy (nerve disease causes weakness, numbness, burning pain.) R1's IAPP dated August 11, 2021 indicated R1 was at risk of abuse to self and others due to current medical condition and history. The intervention noted "monitor closely" did not identify in what situations to and not to monitor resident. R1's medication record dated September 2021 indicated R1 did not receive morning medication on September 1, September 23, and September 26, 2021. In addition, R1 did not receive evening medication on September 6, September 12, September 20, 2021 because R1 was not in the facility. During an interview on October 5, 2021, at approximately 11:10 a.m., R1 stated he does not sleep in the facility regularly and is away most of the time. R1 said he came to the facility to get his medication, change, rest or eat but did not stay long. During an interview on October 5, 2021, at approximately 12:50 p.m., unlicensed personnel (ULP)-B stated if R1 was not in the facility for his morning medications he would not get his medications later unless approved by the nurse. ULP-B stated it was not possible to monitor R1	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 630	Continued From page 10 closely if he was not present during her shift. During an interview on October 6, 2021, at approximately 10:40 a.m., registered nurse (RN)-C stated R1 had his own vehicle and directed his own schedule. RN-C stated it was not possible to monitor R1 closely and offered no alternative intervention. RN-C stated the facility did not provide specific resident interventions because the residents were independent. R4's Service Plan, undated, and unsigned indicated R4 received services that included staff assistance with behavior management, medication administration, vital sign monitoring, cleaning, and decluttering. R4's diagnoses included mood disorder, major depressive disorder, cognitive impairment, impulse control disorder, bipolar disorder, suicidal ideation and polysubstance abuse. R4's IAPP dated, August 11, 2021, indicated R4 was vulnerable and at risk of abuse to self and others due to attempted suicide during the past 6 months. Intervention included medication management and a daily safety check. There was no detail of means of suicidal attempt for specific interventions to prevent suicide. An incident report dated September 23, 2021, indicated R4 requested to go to the emergency room for suicidal ideation. R4's IAPP was not updated to include specific safety measures for suicidal ideation. An observation on October 6, 2021, R4's bed mattress was on the floor without a box spring or a bed frame.	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 630	Continued From page 11 During an interview on October 5, 2021, at approximately 12:30 p.m., licensed assisted living director (LALD)-E stated R4 preferred his mattress on the floor. When asked by the surveyor how the floor underneath the mattress was kept clean and dry LALD-E stated staff move the mattress regularly to look underneath it for sharp or dangerous items because R4 had history of harming self. During an interview on October 5, 2021, at approximately 12:50 p.m., ULP-B stated she did not know about R4 hiding sharp or dangerous items under his mattress. ULP-B stated she was not aware that staff checked R4's room for sharp objects. ULP-B stated she was not trained to pick up the bed mattress to complete a search and she did not know about others safety interventions in place for R4. During an interview on October 6, 2021, at approximately 10:35 a.m., RN-C stated there was no plan for staff to check under R4's bed mattress for sharp items. RN-C stated the staff do a safety check each shift for all residents but there is no specific or individualized intervention because the facility does not provide individualized interventions. RN-C stated it would be a good idea to add the intervention to R4's IAPP. A policy titled Vulnerable Adult/Child Protection dated December 1, 2019, indicated a requirement to individually assess clients to determine their vulnerability to abuse and neglect and develop a specific plan to minimize the risk of abuse or neglect to the client and documented in the clinical record. The plan would include specific measures to reduce risk and the plan would be	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 630	Continued From page 12 implemented immediately and evaluated at each supervisory visit or more frequently as necessary No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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; (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 the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all four 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	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 13 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: The licensee lacked the following: (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. On October 5, 2021, at approximately 9:50 a.m., during facility tour, the licensee lacked posting of the above required information in a conspicuous place. On October 5, 2021, at approximately 12:25 p.m., owner (O)- A verified the required posting was missing because they were not aware of the requirement. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 14 (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 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 observation, interview and record review, the licensee failed to ensure an employee record included all required content for one of one employee, unlicensed personnel (ULP)-B with employee record reviewed (TB training, annual reviews and training competency evaluation).	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 15 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 had a hire date of August 25, 2020. On October 5, 2021, at approximately 9:55 a.m., ULP-B was observed passing medications to the assisted living resident (R1). ULP-B's record lacked evidence of: tuberculosis training at hire; annual reviews; and training competency evaluation to include: understanding appropriate boundaries between staff and clients and the client's family, awareness of commonly used health technology equipment and assistive devices, and recognizing physical, emotional, cognitive, and developmental needs of the client. On October 6, 2021, at approximately 12:30 p.m., owner (O)-A stated that the employee had finished all required training but because they were moving offices they had misplaced some employee records. The licensee's policy titled Personnel Records dated December 1, 2019, indicated the licensee will maintain record for each employee providing care services.	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 16 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 17 review, the licensee failed to have a written emergency preparedness plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all four residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 5, 2021, at approximately 9:20 a.m., during the entrance conference a request was made to review the licensee's emergency disaster preparedness plan. On October 5, 2021, at approximately 9:45 a.m., during a facility tour, 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, and no emergency exit diagrams were in each of the four residents' rooms as required. On October 7, 2021, at approximately 10:10 a.m., owner (O)- A provided surveyors with a three ring binder titled Emergency Preparedness. In it contained an undated document titled Emergency Response, Reporting & Review Policy, which was subdivided into sections; Policy, Response	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 18 Procedures, Reporting Procedures, Review Procedures and Record Keeping Procedures. The licensee's plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 19 the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements On October 7, 2021, at approximately 2:10 p.m., O-A confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). O-A also verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 20 (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 observation, interview, and record review, the facility failed to provide documentation of policy, schedule, and log of staff training for fire safety and evacuation procedures. There was no evacuation plan posted in the building. It also failed to provide documentation of required staff evacuation drills. This has the potential to harm all four 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	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 21 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 facility tour on October 5, 2021, at approximately 10:30 a.m., no evacuation plan was observed in the building. A policy related to a plan for required training of employees and evacuation drills was not available. On October 5, 2021 at approximately 11:15 a.m., owner (O)-A, confirmed the facility had not developed a plan showing exit routes out of the building. She also confirmed that a schedule and log for required training and evacuation drills had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 900	Continued From page 22 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for two of four residents (R1, R4) 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	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 900	Continued From page 23 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: The licensee transitioned from a Comprehensive level license to an Assisted Living license on August 1, 2021. R1 and R4's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable In addition, R1 and R4's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On October 5, 2021, at 11:30 a.m., R1 stated he has not received new contract information from the facility.	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
0 900	Continued From page 24 On October 6, 2021, at 2:45 p.m., owner (O)-A, O-F and licensed assisted living director (LALD)-E stated none of the residents have signed a new contract for the new Assisted Living Licensure requirements, effective August 1, 2021 because they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01470	Continued From page 25 (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 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one employee records reviewed, unlicensed personnel (ULP)-B, received orientation to assisted living facility licensing requirements and regulations.	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01470	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of August 25, 2020. On October 5, 2021, at approximately 9:50 a.m., ULP-B was observed to pass medications to the assisted living resident R1. ULP-B's record lacked evidence of orientation to home care regulations 144G.63 subd. 2 completed prior to providing home care services to residents to include; - Overview of Home Care/Assisted Living statutes - Review of provider's policies and procedures - Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license - Principles of person-centered planning/service delivery On October 7, 2021, at approximately 1:40 p.m., owner (O)-A, and registered nurse (RN)-C verified ULP-B's record lacked orientation to assisted living licensing requirements and regulations. O-A stated the records were missing because some had been misplaced while they moved documents around in the process of changing offices. The licensee lacked policies to include the new	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01470	Continued From page 27 Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be 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 observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two employees, unlicensed personnel (ULP)-B, and licensed assisted living director (LALD)-E 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 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:	01480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 28 ULP-B had a hire date of August 25, 2020. ULP-B personnel file lacked documentation of orientation to each individual resident (R) and their needs prior to providing services. On October 5, 2021, at approximately 9:35 a.m., ULP-B assisted R4 with medication administration and breakfast. On October 5, 2021, at 10:00 a.m., ULP-B assisted R1 with medication administration and blood glucose check. On October 7, 2021, at approximately 10:20 a.m., LALD-E provided a safety check to R4. During an interview on October 5, 2021, at approximately 12:30 p.m., LALD-E stated staff moved R4's bed mattress regularly to look underneath for sharp or dangerous items because R4 had history of harming himself. LALD-E did not recall being specifically oriented to this practice. During an interview on October 5, 2021, at approximately 12:50 p.m., ULP-B stated she did not know about R4 hiding sharp or dangerous items under his mattress. ULP-B stated she was not aware that staff checked R4's room for sharp objects. ULP-B stated she was not trained to pick up the bed mattress to complete a search. ULP-B stated she did not know about other safety interventions in place for R4. During an interview on October 6, 2021, at approximately 10:40 a.m., registered nurse (RN)-C stated the facility did not orient each staff member to each resident because resident interventions were not individualized or specific to	01480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 29 the resident because the residents all lived independently. During an interview on October 7, 2021, at approximately 10:35 a.m., RN-C and owner (O)-A stated orientation to services were provided to staff but an individualized orientation specific to each resident was only done for something unusual like a dressing change. A policy titled Service plan dated December 1, 2019, indicated staff would be oriented to each resident's service plan. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01480		
01500 SS=F	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	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 30 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 31 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee, unlicensed personnel (ULP)-B with training 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, 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 of the residents). The findings include: ULP-B had a hire date of August 25, 2020. On October 5, 2021, at approximately 9:50 a.m., ULP-B administered medications to the assisted living resident (R1). ULP-B's record lacked evidence of annual training to 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	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 32 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased 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	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 33 access in real time, and closed captions. On October 7, 2021, at approximately 1:55 p.m., owner (O)-A acknowledged annual training had not been completed for ULP-B or any of the licensee's staff due to Covid-19. O-A stated there was a plan in place to complete annual training for 2021 for the licensees' employees. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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 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,	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 34 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 the service plan was revised based on assessment and changes in services for two of two residents (R1, R4) with records reviewed. In addition, the licensee failed to update staff to the current service plan. 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: R1's service plan dated March 27, 2021 indicated R1 received assistance with ACE wrap (an elastic bandage to create compression to a localized area) and TEDs (thrombo embolus deterrent also known as a compression or anti embolism stocking), medication administration and monthly registered nurse (RN) nail care. In addition, R1's plan listed behavior management and safety checks three times daily. R1's assessment dated August 11, 2021, indicated R1 required assistance with "special dressing needs" that included ACE wrap and TED	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 35 hose daily. Nurse nail care was not listed on the document. The assessment indicated R1 had no social, cognitive, or behavioral concerns. The licensee failed to update R1's service plan to discontinue need for behavior monitoring, nurse nail care and ACE wraps and TED hose. R4's service plan, undated and unsigned, indicated R4 received services that included staff assistance with behavior management, medication administration, vital sign monitoring, cleaning, and decluttering. R4's diagnoses included mood disorder, major depressive disorder, cognitive impairment, impulse control disorder, bipolar disorder, suicidal ideation and polysubstance abuse. R4's individual abuse prevention plan (IAPP) dated August 11, 2021, indicated R4 was vulnerable and at risk of abuse to self and others due to attempted suicide during past six months. Intervention included medication management and a daily safety check. R4's assessment dated August 11, 2021 indicated R4 had no history or active problems with cardiac or respiratory function. R4 required daily safety check and denied suicidal ideation but had history of self-harm. R4 was a low fall risk but staff would provide hourly checks to address fall risk. RN would follow up on any health changes, appointments and emergency room visits. The licensee failed to update R4's service plan to include safety checks. An incident report dated September 23, 2021, indicated R4 requested to go to the emergency	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 36 room for suicidal ideation. No further information provided. The licensee again failed to update R4's service plan to include safety checks. A document titled Incident Report dated October 3, 2021, indicated R4 went to the emergency room for elevated blood pressure and pulse and returned with new medication orders. During an interview with unlicensed personnel (ULP)-B on October 5, 2021, at approximately 12:10 p.m., ULP-B stated that RN-C was present early that morning to add a new medication to R4's medication box. ULP-B stated RN-C provided an update to ULP-B on the diagnosis and medication change and that ULP-B would pass information to the oncoming staff at shift end. ULP-B stated the usual communication of changes to a resident plan was verbalized between ULPs when switching shifts. During an interview on October 5, 2021, at approximately 12:30 p.m., licensed assisted living director (LALD)-E stated R4 preferred his mattress on the floor. When asked by the surveyor how the floor underneath the mattress was kept clean and dry LALD-E stated staff move the mattress regularly to look underneath it for sharp or dangerous items because R4 had history of harming himself. During an interview on October 5, 2021, at approximately 12:50 p.m., ULP-B stated she did not know about R4 hiding sharp or dangerous items under his mattress. ULP-B stated she was not aware that staff checked R4's room for sharp objects. ULP-B stated she was not trained to pick up the bed mattress to complete a search. ULP-B	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 37 stated she did not know about others safety interventions in place for R4. During an interview on October 6, 2021, at approximately 10:35 a.m., RN-C stated it was not uncommon for R4 to request a visit to the emergency department also not uncommon for R4 to talk about suicide. RN-C said there was no change in R4 therefore no assessment or service plan update was required when R4 was hospitalized. RN-C stated she was on vacation yesterday but came to the facility to add a new medication to R4's medication box. During an interview on October 7, 2021 at approximately 10:00 a.m., owner (O)-A and RN-C stated they were aware that assessments required updates but did not know that the service plans also required review and/or revision with changes in resident needs under the new Assisted Living Licensure for service plan requirements and agreed no residents have received a new service plan for current requirements. A policy titled "Service Plan" dated December 1, 2019, indicated an individualized service plan would be implemented for all residents based on a comprehensive assessment, the resident's preferences and needs. The service plan would be revised based on changes in needs. The facility would implement and provide all services required by the service plan and the staff who provided the services would be oriented to the plan. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021.	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 38 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01770 SS=D	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 ensure documentation of medication setup included all the required content for one of two residents (R1) 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 October 5, 2021, at approximately 9:15 a.m., owner (O)-A stated the licensee provided medication management services which included medication setup by the registered nurse (RN) for their	01770		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 39 residents. On October 5, 2021, at approximately 10:10 a.m., unlicensed personnel (ULP)-B dispensed medications to R1 from a pill box. R1's Master Care Plan dated August 11, 2021, indicated he received services to include: daily blood sugar checks, medication administration including set up by registered nurse, daily reminders to take medications and assistance with activities of daily living. R1's record lacked documentation by the licensed nurse at the time of medication setup to include: documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. On October 7, 2021, at approximately 11:30 a.m., RN-C, verified she was setting up medications for all the licensee's residents and documented in her nursing notes "medication set up completed" every week when she set up the medication. She also acknowledged the required content identified above was missing in the client notes. The licensee's undated Medication Management Program policy lacked the required verbiage for medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 40	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions. In addition, the licensee failed to monitor the refrigerator temperature. 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 of the residents). The findings include: On October 5, 2021, at approximately 10:45 a.m., the surveyor in the presence of owner (O)-A and O-F, observed the contents of the unlocked medication refrigerator that included: opened box of Novolog Flexpen 100 unit/milliliter (ml) with an expiration date of January 19, 2022, opened box of lantus solostar 100 units/ml with an expiration date of March 25, 2022, and an opened box of Victoza injection 18 milligram/milliliter, with an expiration date of October 2022.	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 41 On October 5, 2021, at approximately 10:50 a.m., during observation, the refrigerator cord was unplugged and the contents of the refrigerator were at room temperature to touch. The manufacturer's instructions for Novolog 70/30 insulin Flexpen, dated April 28, 2021, indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog 70/30 to freeze. The manufacturer's instructions for undated Lantus insulin pens, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Victoza indicated to store unopened Victoza pen in a refrigerator at 36°F to 46°F and after opening at room temperature for 30 days. On October 5, 2021, at approximately 10:55 a.m., O-A and O-F were requested to provide with the refrigerator's daily temperature log, O-A stated that they did not keep a log and there was no thermometer in the medication refrigerator. The licensee's policy for medication storage and security requested but was not provided. 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	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 42 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 ensure an opened insulin pen was dated correctly. In addition, the licensee failed to discard expired medications for one of three residents (R1) 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). Findings include: On October 5, 2021, at approximately 9:45 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's medications included: amlodipine 2.5 milligram (mg) by mouth daily, aspirin 81 mg, two tablets by mouth daily, furosemide 20 mg by mouth daily, lisinopril 40 mg by mouth daily, metformin 500 mg ER four tablets by mouth daily, lantus solostar 100 units/milliliter, inject 30 units subcutaneous daily. R1's physician orders dated October 7, 2021,	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 43 included: Advair Hfa 230/21 inhaler, inhale two puffs by mouth twice daily, afterward rinse mouth with water and spit, furosemide 20 milligram (mg) tablet give one tablet by mouth daily, Lantus solostar pen 100 unit/milliliter (ml) inject 30 units subcutaneously once daily, lisinopril 40 mg tablet give one tablet by mouth daily, metformin 500 mg tablet take four tablets by mouth once daily, monitor blood glucose daily, record temperature three times daily, symptom screening two times daily. On October 6, 2021, at approximately 10:40 a.m., when R1's medication box was observed there was an opened insulin pen (Lantus solostar pen) unlabeled with the date it was opened or expiration date. Expired medications included: furosemide expired June 9, 2021, tamsulosin expired June 6, 2021, omeprazole expired April 10, 2021, duloxetine expired October 13, 2020, lisinopril expired June 11, 2021. The manufacturer's instructions for Lantus solostar indicated the pen should be discarded after 28 days after first use. On October 6, 2021, at approximately 11:10 a.m., registered nurse (RN)-C confirmed all insulin pens should be dated when opened, she also stated she had sorted the expired medications for disposal but was waiting on the pharmacy to give her an appointment to take them in. The licensee's policy Disposal of Medication dated December 1, 2019, indicated the licensee will dispose any expired medications they manage according to the accepted practices of the Minnesota board of Pharmacy. No further information provided.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 44	01890		
01910 SS=D	TIME PERIOD FOR CORRECTION: Seven (7) days. 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 observation, interview and record review, the licensee failed to ensure medications discontinued or expired had been disposed of properly and documented in the discharged resident's record, for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 45 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was discharged from the licensee on September 15, 2021. On October 5, 2021, at approximately 10:45 a.m., the surveyor in the presence of owner (O)-A and O- E, observed the contents of the unlocked medication refrigerator that included R3's insulin medications: opened box of Novolog Flexpen 100 unit/milliliter (ml), expiration date January 19, 2022, opened box of Lantus solostar 100 units/ml, expiration date March 25, 2022, and opened box of Victoza injection 18 milligram/milliliter, expiration date October 2022. R3's record lacked evidence of documentation to include 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. On October 5, 2021, at approximately 1:12 p.m., registered nurse (RN)-C verified R3's record did not include documentation of medication disposition as noted above. RN-C also stated that R3's medication in the refrigerator may have been sent from the pharmacy recently while she was out on vacation. The licensee's policy Disposal of Medication dated December 1, 2019, indicated the licensee	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 46 would dispose medications they manage according to the accepted practices of the Minnesota board of Pharmacy and they will document to include all the missing content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01910		
01940 SS=G	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 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	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 47 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 ensure treatments were performed as ordered for one of two residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: R1's Service Plan dated March 27, 2021, indicated R1 received services that included staff assistance with blood glucose (BG) monitoring. R1's diagnoses included diabetes. R1's physician orders dated October 7, 2021 indicated R1 required assistance with BG monitoring daily. R1's assessment dated August 11, 2021, indicated R1 required assistance with daily BG monitoring that included documentation of the result and close monitoring. Registered nurse (RN) would assess closely for "frequent dosage changes or review of lab tests for BG monitoring."	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 48 R1's Medication Management Plan dated, August 11, 2021, indicated RN/unlicensed personnel (ULP) would closely monitor BG results and update the doctor as needed. The plan did not indicate specific BG parameters for R1. R1's record lacked BG parameters from R1's physician. During an observation on October 5, 2021, at approximately 10:00 a.m., R1 checked his BG under ULP-B's supervision and ULP-B documented the result as 147 milligrams per deciliter (mg/dl). During an interview with R1 on October 5, 2021, at approximately 10:00 a.m., R1 stated he didn't know what the parameters were for his BG results. R1 stated once it had been very low and luckily the staff gave him food. During an interview with ULP-B on October 5, 2021, at approximately 10:10 a.m., ULP-B stated there was no known parameter for R1's BG and she did not know what was normal for R1. R1's Service Record dated October 5, 2021, for BG task indicated, "wearing gloves and following agency procedure, check blood glucose and record. Notify RN if: BS not within range." There was no BG range for staff to reference. During a record review of R1's BG log for the month of August 2021, R1 did not have BG record result on August 4, August 10, August 11, and August 24. R1's BG results ranged from 90 - 327. Upon review of the September 2021 BG log, R1 did not have a BG record result on September 1, September 6, September 7, September 8, September 10, September 11, September 12,	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 49 September 13, September 15, September 16, September 17, September 18, September 19, September 20, September 21, September 22, September 23, September 24, September 27, September 28, September 29, and September 30. R1's BG results ranged from 150-292. R1's nurse progress notes during the months of August 2021 and September 2021 indicated RN-C noted on August 2, 16, 23 and 30 that RN-C was in the home for medication refill and assessment. RN-C documented verbatim in each note, "no acute changes reported at this time, Client blood sugar reading, and vitals noted in Rtask" and R1 "denied signs of hyper/hypoglycemia". During the month of September 2021, RN-C indicated on September 3, 11, 16, and 24th, a visit note that repeated the same content, "no acute changes reported at this time, Client blood sugar reading, and vitals noted in Rtask" and R1 "denied signs of hyper/hypoglycemia". R1's record lacked evidence that the prescriber was notified of the missed BG results. The record lacked parameters for R1's BG results. The record lacked guidance for staff providing the service what to do if BG was missed and what the normal parameters are for R1's BG and when to call the RN to report a change or concern with the BG monitoring. During an interview on October 6, 2021, at approximately 10:00 a.m., RN-C stated she did not notify the physician of the missed BG monitoring. RN-C did not know R1's specific BG parameters and agreed the parameters should be obtained and added to R1's plan. A policy titled Treatment and Therapy	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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 50 Management dated December 1, 2019, indicated treatment protocols were consistent with evidence-based practice standards. In addition, the RN was responsible for assessing and developing a treatment plan that included monitoring and evaluation of the effectiveness of the treatment. Care coordination the resident's provider and staff. In addition, the plan would include an individualized plan to prevent complications and procedures for notifying the RN. A policy titled Physician Orders dated Dec 1, 2019, indicated all medically delegated services were required to be under a prescriber's order. A written order for all medications and treatments must be signed and dated by the provider. The RN was responsible for implementing all treatment orders and for delegation to ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse:	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 51 "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all residents had received and had written acknowledgment of receipt of the Minnesota Bill of Rights for Assisted Living Residents and information about how to	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 52 make a complaint for one of one residents (R1) with record review. 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: The licensee transitioned from a Comprehensive level license to an Assisted Living license on August 1, 2021. R1's record had an admission date of October 26, 2020. R1's record acknowledged the 2019 Minnesota Home Care Bill of Rights. R1's record lacked a copy and signed acknowledgement of the Minnesota Bill of Rights for Assisted Living Residents or information on how to make a complaint. On October 5, 2021, at 11:30 a.m., R1 stated he had not received information on the Minnesota Bill of Rights for Assisted Living Residents or information on how to make a complaint. On October 6, 2021, at 2:45 p.m., owner (O)-A indicated none of the residents received a copy of the Minnesota Bill of Rights for Assisted Living Residents or information on how to make a complaint because the provider was unaware of the requirement. An outdated policy titled Notification Policy dated	02240		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER BEATITUDES HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 84TH AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 53 December 1, 2019, indicated the facility would provide a written notice of the Bill of Rights and instructions on how file a complaint. In addition, the policy indicated a signed receipt prior to providing services would be retained in the clinical record. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

Type: Full
Date: 10/05/21
Time: 10:00:00
Report: 1005211225

Food and Beverage Establishment Inspection Report

Page 1

Location:

Beatitudes Home
1609 84th Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:

ID #: N#N0002
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
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.

IN THE REFRIGERATOR, A PACKAGE OF RAW GROUND BEEF WAS STORED IN THE BREAD DRAWER. RAW CHICKEN WAS STORED NEXT TO LUNCH MEATS. ALL RAW MEATS SHOULD BE STORED IN THE BOTTOM DRAWER, BELOW ANY READY-TO-EAT FOODS.

Comply By: 10/05/21

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.

SOME FOODS WERE DATE-MARKED, BUT MANY WERE NOT, INCLUDING COOKED PASTA, OPENED MILK, AND OPENED LUNCH MEAT. DISCUSSED MARKING THE DATE THAT FOODS ARE OPENED OR PREPARED, SO THEY ARE USED OR DISCARDED WITHIN 7 DAYS.

Comply By: 10/05/21

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THERMOMETER IS AVAILABLE FOR TAKING FOOD TEMPERATURES.

Type: Full
Date: 10/05/21
Time: 10:00:00
Report: 1005211225
Beatitudes Home

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 10/12/21

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE IS AVAILABLE FOR MEASURING THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. DISCUSSED OPTIONS WITH OPERATOR, SEE COMMENTS.

Comply By: 10/12/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THE KITCHEN HAS A DOUBLE BASIN SINK. ONE SIDE HAD CHICKEN THAWING IN IT, THE OTHER SIDE HAD DIRTY DISHES STORED IN IT. DESIGNATE ONE BASIN FOR HANDWASING AND DO NOT USE FOR OTHER PURPOSES.

Comply By: 10/05/21

2-100 Supervision

2-102.12AMN

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

THE OWNER / PROGRAM MANAGER IS ALREADY ENROLLED IN A FOOD SAFETY COURSE. AFTER COMPLETING THE COURSE, SUBMIT CERTIFICATE TO MDH TO RECEIVE THE MN CFPM.

Comply By: 11/05/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

IN THE BASEMENT PANTRY / CRAWLSPACE, PACKAGED FOOD IS STORED DIRECTLY ON THE FLOOR. PROVIDE SHELVING SO FOOD IS STORED AT LEAST 6 INCHES ABOVE THE FLOOR.

Comply By: 11/05/21

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

CHICKEN WAS OBSERVED THAWING AT ROOM TEMPERATURE AND WAS ALREADY 55 DEGREES F. TCS FOODS SHOULD BE THAWED IN THE REFRIGERATOR, TO AVOID

Type: Full
Date: 10/05/21
Time: 10:00:00
Report: 1005211225
Beatitudes Home

Food and Beverage Establishment Inspection Report

Page 3

POSSIBLE CROSS-CONTAMINATION OF HANDWASHING SINK.

Comply By: 10/05/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

THE ONLY THERMOMETER IN THE REFRIGERATOR IS THE IN-LINE, DIGITAL DISPLAY.
PROVIDE AN AMBIENT AIR THERMOMETER IN THE WARMEST PART OF THE REFRIGERATOR
(THIS IS TYPICALLY THE BOTTOM, FRONT).

Comply By: 10/12/21

Food and Equipment Temperatures

Process/Item: Cold Hold/CHICKEN WING

Temperature: 41 Degrees Fahrenheit - Location: SAMSUNG KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/PASTA

Temperature: 38 Degrees Fahrenheit - Location: SAMSUNG KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/WATERMELON

Temperature: 37 Degrees Fahrenheit - Location: SAMSUNG KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/HAM

Temperature: 40 Degrees Fahrenheit - Location: SAMSUNG KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Cold Hold/BACON

Temperature: 41 Degrees Fahrenheit - Location: SAMSUNG KITCHEN REFRIGERATOR

Violation Issued: No

Process/Item: Thawing/CHICKEN

Temperature: 55 Degrees Fahrenheit - Location: IN SINK, AT ROOM TEMPERATURE

Violation Issued: Yes

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	4	4

INSPECTION COMPLETED WITH PROGRAM MANAGER AND EMPLOYEES.

REVIEWED REPORT WITH PERSON IN CHARGE, ZOE BOIMAH, AND HEALTH REGULATION
DIVISION NURSE EVALUATOR, BENARD NYANGENA.

DISCUSSED ALL ORDERS ON REPORT, AS WELL AS:

-HANDWASHING

-BARE HAND CONTACT AND GLOVE USE

Type: Full
Date: 10/05/21
Time: 10:00:00
Report: 1005211225
Beatitudes Home

Food and Beverage Establishment Inspection Report

Page 4

- EMPLOYEE ILLNESS
- CROSS-CONTAMINATION
- COOK TEMPERATURES FOR RAW ANIMAL FOODS

UNTIL FACILITY CAN OBTAIN THEIR OWN IRREVERSIBLE TEMPERATURE MEASURING DEVICE, THERMOLABELS WERE LEFT ON SITE SO FACILITY CAN VERIFY THAT THEIR DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE. THE DISHWASHER WILL LIKELY NEED TO BE RUN ON THE "SANITIZE" CYCLE TO ACHIEVE THIS TEMPERATURE.

THE CEILING IN THE KITCHEN HAS A POPCORN FINISH, WHICH IS NOT EASILY CLEANABLE. WHEN THIS CAN NO LONGER BE MAINTAINED CLEAN, THE CEILING WILL NEED TO BE REFINISHED OR REPLACED TO BE SMOOTH AND EASILY CLEANABLE.

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 1005211225 of 10/05/21.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

ZOE BOIMAH
OWNER / PROGRAM MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us

Report #: 1005211225

Food Establishment Inspection Report



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

No. of RF/PHI Categories Out

4

Date 10/05/21

No. of Repeat RF/PHI Categories Out

0

Time In 10:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Beatitudes Home

Address

1609 84th Avenue North

City/State

Brooklyn Park, MN

Zip Code

55444

Telephone

License/Permit #

N#N0002

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

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	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 Hygienic 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	No bare hand contact with RTE foods or pre-approved alternate procedure 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	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A	Required records available; shellstock tags, parasite destruction		

Protection from Contamination

15	IN	OUT	N/A	Food separated and protected		
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	Proper cooking time & temperature		
19	IN	OUT	N/A	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	Proper cooling time & temperature		
21	IN	OUT	N/A	Proper hot holding temperatures		
22	IN	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A	Proper date marking & disposition		
24	IN	OUT	N/A	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		

Conformance with Approved Procedures

29	IN	OUT	N/A	Compliance with variance/specialized process/HACCP		
----	----	-----	-----	--	--	--

Risk factors (RF) are improper practices or procedures 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	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	Approved thawing methods used		
36	X			Thermometers provided & accurate		

Food Identification

37				Food properly labeled; original container		
----	--	--	--	---	--	--

Prevention of Food Contamination

38				Insects, rodents, & animals not present		
39	X			Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

Food Recalls:

Person in Charge (Signature)

Date: 10/06/21

Inspector (Signature)